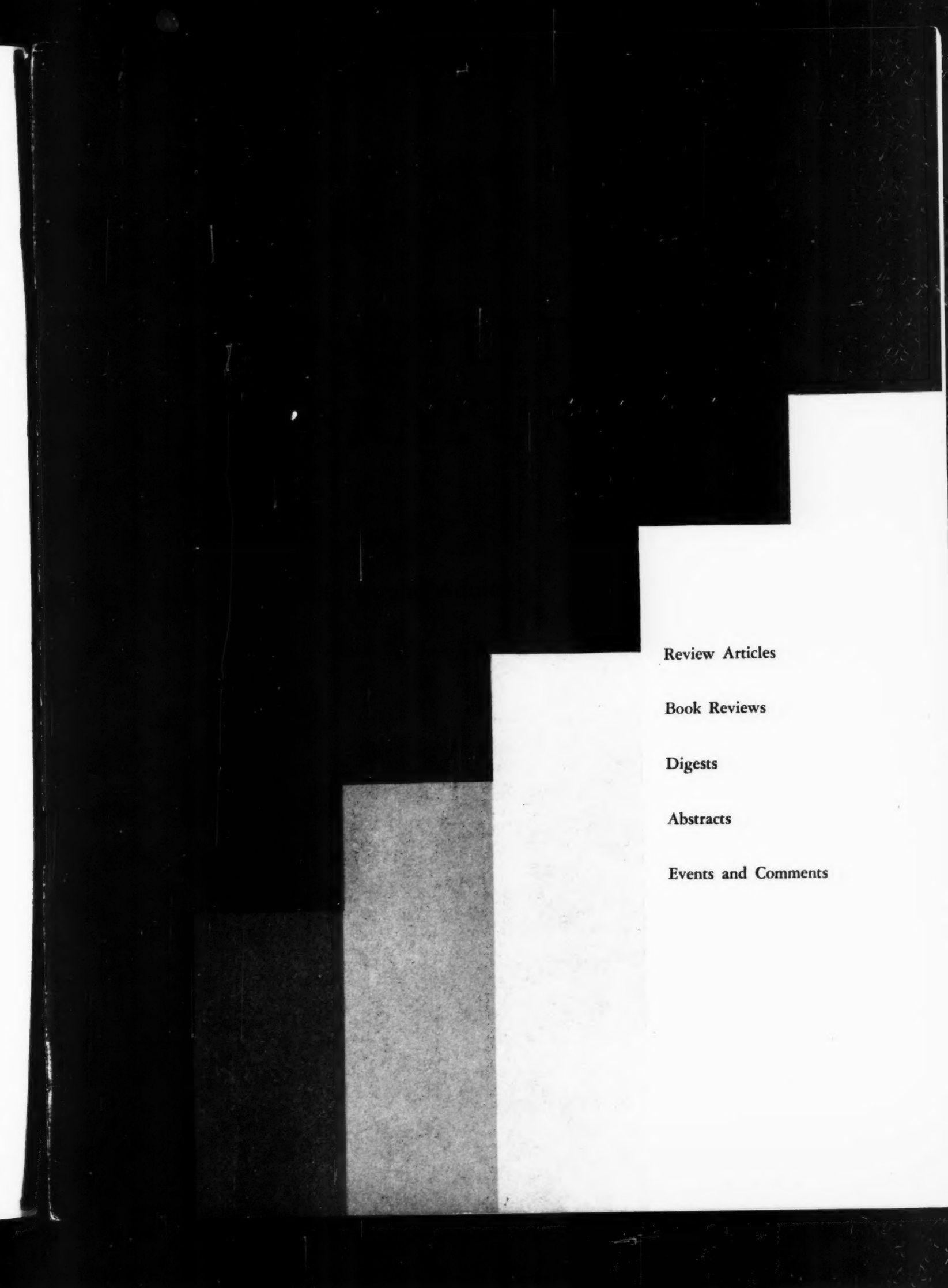
Review Articles
Book Reviews
Digests
Abstracts
Events and Comments

*Rehabilitation Literature* is intended for use by professional personnel and students in all disciplines concerned with rehabilitation of the handicapped. It is dedicated to the advancement of knowledge and skills and to the encouragement of co-operative efforts by professional members of the rehabilitation team. Goals are to promote communication among workers and to alert each to the literature on development and progress both in his own area of responsibility and in related areas.

*Rehabilitation Literature* is in no sense the house organ of the National Society for Crippled Children and Adults. Contributors of feature articles and book reviews are people of standing in their own fields and give free expression to their own ideas and opinions.

As a reviewing and abstracting journal, *Rehabilitation Literature* identifies and describes current books, pamphlets, and periodical articles pertaining to the care, welfare, education, and employment of handicapped children and adults. The selection of publications listed and their contents as reported is for record and reference only and does not constitute an endorsement or advocacy of use by the National Society for Crippled Children and Adults.

The National Society for Crippled Children and Adults does not stock for sale publications indexed in *Rehabilitation Literature*. List prices and addresses of publishers are given for information only. Copies should be obtained directly from the publisher or through local bookstores. Known addresses of authors of periodical articles follow their names.

Books for review and correspondence relating to feature articles and other editorial matters should be addressed to the editor. He will welcome your suggestions.

# REHABILITATION LITERATURE

## CONTENTS

March, 1961, Volume 22, No. 3



Published Monthly by
National Society for Crippled Children and Adults, Inc.
2023 West Ogden Avenue, Chicago 12, Illinois
Dean W. Roberts, M.D., Executive Director
Second class postage paid at Chicago, Illinois.
Subscription rates: $4.50 a year, United States; $5.00 a year, other countries. Single copy: 50¢, United States; 60¢, other countries.

Editorial Staff
Earl C. Graham, Editor
Helen B. Crane, Staff Editor
Marjorie M. Mullen, Abstracts Editor
Address changes must be received by the 10th of the month to take effect the following month.

# REHABILITATION LITERATURE

*Article of the Month*

## Significance of Public Attitudes in The Rehabilitation of The Disabled

**G. Allan Roeher, Ph.D.**

**About the Author . . .**

*Dr. Roeher is co-ordinator of rehabilitation for the government of Saskatchewan, Can., and director of the Co-ordinating Council on Rehabilitation, Saskatchewan, a province-wide, jointly sponsored and financed co-ordinating and planning organization incorporating all provincial and federal government departments and voluntary agencies associated with rehabilitation. After graduation from the University of British Columbia, he received his M.A. and Ph.D. degrees from New York University. Dr. Roeher in 1949 joined the Research and Statistics Division, Department of Public Health, to survey problems of the long-term hospitalized ill, subsequently establishing the first medical social work department to rehabilitate the chronically ill from hospitals. In 1953 he was appointed executive director of the Saskatchewan Council for Crippled Children and Adults, which pioneered conjoint programing among voluntary agencies.*

*This original article was written especially for Rehabilitation Literature.*

IN SPITE OF INTENSIVE application of rehabilitation services, we fail in our efforts to habilitate, or rehabilitate, adequately countless numbers of disabled. Using the measure of success as the extent to which these individuals subsequently function as *socially normal* persons (except for actual residual physical and mental limitations), many fail to realize their potential. Varied reasons can be, and are attributed to: their lack of motivation; inadequate opportunity to prove themselves; limited acceptance by society; or asocial personality and behavior traits—all by-products of adverse environmental forces. The problem is not one of physical neglect or inadequate treatment resources but is much more deep-rooted in the negative attitudinal and emotional reactions of society toward its handicapped members.

Tenny[1] succinctly expresses the problems facing the disabled in terms of *limitations* as: limitations imposed by functional loss due to the physical impairment itself; limitations imposed upon the handicapped person by society; and self-imposed limitations of withdrawal or aggression resulting from the handicap and society's attitude toward it.

The diverse and extensive services mobilized within the framework of the modern rehabilitation movement are designed essentially to overcome the limitations of the physical impairment itself. To the extent that physical deformity has been corrected, individuals have been removed from their minority status in society. Even though function has been improved, perhaps to the point where economic independence is potentially feasible, those still left with visible impairment behave and react differently to their problem. For them there seems to be a lack of correlation between physical and mental potential and their ultimate level of function as self-sustaining members of society. Certain persons, for example, with slight disabilities become totally dependent and resigned to an unproductive life, while others with greater physical disabilities achieve independence and frequently an unusual degree of

success. It would appear, therefore, that like defects do not produce similar types of maladjustment and degrees of dependency, and it may be hypothesized that the difficulty does not stem from physical causes alone.

Social scientists observing the situation have ventured a theory to explain the cause as social. Man is a social being whose behavior depends on the nature of his social contacts.[2] The modern sociological concept views disability to a large extent as a function of cultural and social factors. The nature and degree of handicap, in the final analysis, are based on cultural definitions and social perceptions and are so interpreted to the disabled person by the people with whom he associates. The basic social process is interaction, whereby an individual learns how to become an accepted member of society and about the standards of behavior expected of him.

### The Attitude Concept

The constellation of cultural judgments regarding an individual or a group of persons and the standards of behavior expected of them are made manifest by a psychological entity known as *attitude*.* The ways of looking at things and persons, forms of readiness, approaching and withdrawing behavior, feelings of rightness and wrongness, and liking or disliking objects or values are all geared to the usual working concept of attitudes.[3] The concept is coterminous with such other psychological constructs as interests, appreciations, motives, mores, morality, morale, ideals, prejudices, fears, sentiments, and loyalties. "From the point of view of the individual, attitudes constitute the individual's own evaluation of his conduct and desires in relation to the system of social values as he understands them."[3]

### The Effect of Negative Attitudes on Disability

Prevailing attitudes, as has been indicated, determine the social expectations and treatment accorded an individual in society. Such treatment determines personality. Normal treatment by society produces normal personality, exceptional treatment exceptional personality.[4] The physically handicapped individual is profoundly influenced by society's indication as to his role and status of behavior. Studies show that the self-image of the handicapped child often is a reflection of social stereotypes or a reaction to them; rejection, for example, produces inferiority, self-consciousness, and fear. Crippled children compare themselves unfavorably to other children. The individual perceives himself as incompetent, distorted, and unacceptable, yet he is forced continually to "live with himself" with the cognizance that there is no escape.

Hentig[5] postulates that, aside from perception of the mechanic disability, the individual's eventual "self-image" is the product of a three-stage mental reflection through: 1) inspection of one's own defects, 2) suspicious interpretation of facial expressions, actions, and words of associates, and 3) the accumulation of impressions as to other people's attitudes, both true interpretations and misconstructions, regarding disablement.

The consequent manifestation of this maladjustment is withdrawal, which may assume many forms. Religious "cushioning" of the feeling of inadequacy, for instance, is one form in which the compensatory rationale may be a notion of moral superiority, future recognition, and reward. Fanatical withdrawal is another form, possibly a way of seeking attention; securing praise (for modesty in bearing misery) may be another means of gaining recognition and perhaps affection. Another form of withdrawal is identification with one's own kind.

Hentig explains the dynamics of progressive behavior as follows:

> Being treated as an outsider the disabled establishes himself as an outsider, he retreats from the world of duties since some rights are denied, he slips into that minority complex in which people feel perfect and superior because they are maltreated and misused. Emotionally a satisfying compensation, the attitude is no adequate adjustment to the forces of reality. The mental balance is not squared but thrown into greater disorder.[5]

Behavior in the other extreme, namely, aggressiveness, also occurs. Here the defect has an activating effect and the individual grows extremely competitive, to the point where he refuses to admit he is incapacitated in any way—a wishful amnesia or bravado attitude that is sometimes useful in rehabilitation if carried through.

It is necessary to distinguish between children and adults in describing the social-psychological position of physically disabled persons. The negative attitude of society envelops the child in a vicious circle: "He is handicapped, society sympathizes, over-protection results, the child feels over-protected in terms of what he sees society doing for his non-handicapped friends, he feels frustrated."[6] As the child's world expands beyond the family limits, disadvantageous forces may begin to operate. Because he is disabled, less may be expected of him and he may be unnecessarily helped in many ways. The psycho-

---

*Since a satisfactory eclectic concept of the term *attitude* does not exist, the arbitrary one generally accepted in the measurement field is used: An attitude is a disposition to evaluate certain objects, actions, and situations in certain ways.[17]

The term *prejudice* is used as meaning an adverse or negative attitude toward a group of people in society, based on preconceived judgments about individuals, without just grounds or sufficient knowledge of the facts.

*Disabled* and *handicapped* are other general terms to which various meanings and interpretations are attached because of the variability in degree and type of impairment among individuals. No differentiation is made between the terms. There is support for this approach in the findings of two major attitude studies. Force[7] found, "There was enough evidence of the influence of physical condition on choosing to infer that there was early and continuous minority group identification, based apparently on the label 'handicapped' . . ." McBride[24] found little or no consistency in an individual's attitudes toward such various disorders as cerebral palsy, tuberculosis, blindness, deafness, facial disfiguration, and poliomyelitis.

logical results of constant help are varied but may contribute to loss of self-esteem and ambition.

A study by Force[7] revealed that few physically disabled children have enough positive assets to offset completely the negative effect of being labeled handicapped by normal peers. However, he found that, "The individual physically handicapped child who is highly accepted by a peer group manifests many socially desirable traits and relatively few negative traits of behavior patterns."

When the child becomes an adult, he faces, in addition to the family and the clique group, a rather well-structured social status, which is variously underprivileged, ambiguous, and marginal.[8] When the gap of social distance seems too great to bridge, some retreat to a more tolerable psychological situation—a phenomenon well recognized in psychology. Others go in quest of groups in which a common wrong, real or imaginary, has abolished social distance, such as social groups for the adult handicapped. The self-imposed limitations of withdrawal or aggression are, therefore, a by-product of the handicap itself and society's attitude toward it.

Certain members, in spite of continuing residual disability, succeed in bridging the social distance between themselves and others in their environment. Through "supreme exertion they gain admiration and recognition and establish, thereby, blessing, social proximity, and warming contact."[5] Others, unable to reduce the social distance, develop defense mechanisms that manifest themselves in the logical categories of "fight" or "retreat."

### The Effect of Negative Attitudes on Rehabilitation Programing

Administrators, supervisors, and other workers in the field have given only occasional and relatively superficial attention to the matter of a suitable social climate for the handicapped in society. However, as necessary facilities and staff reach the stage of even minimal adequacy and, as the files of the mildly involved and highly motivated segment of the caseload are closed as "rehabilitated," agencies are becoming increasingly concerned about the residue: persons with seemingly positive prognosis whose progress is stagnant.

One of the most perplexing of all rehabilitation challenges, and one entailing the greatest per capita expenditure with consequent disappointing results, is the rehabilitation of the brain-injured, specifically the cerebral palsied. A number of writers[4, 9, 10] and many therapists designate the influence of society's lack of understanding, interpretation, and reaction as contributing to the tensions intensifying this group's problems of inco-ordination. Rehabilitation organizations may have inadvertently added to the problem with the modern sympathy-oriented type of fund raising.

The effect of the persistent emotional appeal in fund campaigns could well have changed the former apathetic views to sympathetic attitudes. Related literature and practitioners in the field advance many arguments casting doubt on the contention that the public's increased willingness to provide rehabilitation services does, in fact, represent a revision to a positive attitude. In the practice of rehabilitation, many incidents occurring through public contact bear out the premise that there is continued lack of understanding and positive acceptance. Typical incidents involve the employer who donates generously to fund appeals but refuses to employ the disabled and the volunteer who, on visiting a crippled children's camp or treatment center, expresses amazement at the low proportion of severely impaired persons—revealing a perception of disability quite negatively distorted from the real situation. Through depersonalized charity, the general public has apparently been conditioned to envision crippled children as pathetic, helpless creatures warranting sympathy and charity.

### Reasons for Neglect of the Problem

If the aforementioned is the way in which disabled persons solve the problem of social distance, should it not be apparent to administrators and workers in rehabilitation that minimizing the social crisis of the disabled is tantamount to, if not more significant than, the provision of many ancillary rehabilitation measures? It seems paradoxical that, in comparison to the monumental achievements in physical restoration, agencies have, in general, failed to develop effective programs for changing public attitude and that rehabilitation organizations have not been induced to allocate funds for experimental work in modifying the problem.

Various reasons can be advanced for the paucity of objective understanding of the problem and the lack of educational and action programs. Workers and administrators in rehabilitation, absorbed with specific treatment problems, tend to shy away from theoretical investigations as impractical luxury. An assumption also may be that in recent decades attitudes toward the disabled have already undergone significant positive changes. There also is the defeatist attitude. The argument involved here is based on an assumption that attitudes cannot be changed, and, therefore, complete dependence should be placed on perfecting rehabilitation processes. Unfortunately, many disabled will continue through life with obvious limitations, and reliance on improved rehabilitation technics as the total answer is an unrealistic approach—at least for the foreseeable future.

The magnitude of the problem, moreover, makes it untenable to adopt a defeatist proposition that nothing can be done. There is also an ethical responsibility to the disabled and to the public, who have entrusted vast sums of money for alleviation of the problem. This responsibility implies constant evaluation of the effectiveness of current programs. If this is carried out, the matter of change of

public attitude will obtain higher priority than it has in the past.

### Status of Attitudes Toward the Handicapped

*Former Attitudes.*—Literature dealing with social attitudes suggests that emphasis formerly rested primarily on the disabled's passive role of receiving help, without thought of extending encouragement and opportunity to assert himself and to assume interpersonal and community responsibilities.[11] Kessler sums up former attitudes in terms of two great social barriers: psychosocial and economic prejudice and prejudice resting on superstition, misunderstanding, and false concepts of capacity to work.[12]

*Current Attitudes.*—In general, social consciousness is now better developed than in the past, with resultant provision of necessary treatment and ever-expanding opportunities for economic usefulness. Physical disability, however, still magnifies the difficulties of the individual in achieving social acceptance by normal peers. Contemporary society, it is generally agreed, accords the handicapped a sympathetic, charitable, rather than equal status, but variations in cultural definitions and impairments occur within and between family and community settings.

A review of history indicates that societal perceptions and definitions of the handicapped are neither homogeneous nor static. A study by Hanks and Hanks[13] compared the status accorded the physically handicapped in a number of nonoccidental societies and found wide differences. Some cultures completely rejected the handicapped and they became outcasts; in some, they were treated as economic liabilities and grudgingly kept alive by their families; some tolerated and utilized the disabled in incidental ways; in other cultures, they were given respected status and allowed participation to the full extent of their capability. The authors emerge with three hypotheses about social attitudes toward the physically impaired.

Protection of the physically handicapped and social participation for them is increased in societies where: 1) the level of productivity is higher in proportion to the population and its distribution more nearly equal; 2) competitive factors in individual or group achievement are minimized; 3) the criteria of achievement are less formally absolute as in hierarchical social structures and more weighted with concern for individual capacity, as in democratic social structures.[13]

### Similarity with Other Minority Groups

Much of the literature about current attitudes assumes that the physically disabled are subjected to societal attitudes similar to those other minority groups face. Similarities do exist among the handicapped and other minority groups who are such by virtue of race, creed, or nationality in that all: produce social distance; are unfavorably portrayed in literature, drama, and "slapstick" humor; face segregation, particularly in schools; and suffer vocational disadvantage (over and above that involved in the nature of a handicap).

Differences, on the other hand, must be considered: Unlike in other minority groups, the minority status of the handicapped child differs from that of such an adult; family and neighbors do not share the minority status of the handicapped; the handicapped lack the support that comes from home and neighborhood proximity to other handicapped; there are few communities of the handicapped; children who are handicapped do not receive from their home and neighborhood a tailor-made reaction to prejudice and discrimination but must face the majority attitude alone; the handicapped are not alike in their minority status (vary with differences such as in classification, degree of involvement, obviousness); the handicapped do not create social-crises threats.[1]

### Formation and Change of Attitude

*Development of attitudes.*—In the field of social psychology, views are varied as to the concept of attitudes and the elements influencing change in attitude. The notion that attitudes are innately determined or that innate factors are associated therewith is generally discounted by writers. The only suggestions supporting logical argument deal with the possibility that certain specific attitudes depend upon so-called innate temperamental traits; the intensity of an attitude may be related to possibly innate emotional tendencies, and, occasionally, an attitude may be conditioned by one's own physique.[14] Contemporary theories commonly hypothesize that attitudes are learned, beginning in infancy as original drives and overlaid by social experience.

Most of our attitudes (and prejudices) are derived in childhood. The youngster acquires them from parents, playmates, teacher—usually accepted as "factual" information, since children have no reason (or lack knowledge and experience) to doubt remarks made by peers or elders, statements made in literature, or things depicted in motion pictures. Formation of attitude and prejudice need not be on a rational basis.

Pressures toward conformity within a group or society influence development of attitudes in the individual directed toward the mean attitude in the population. Individuals have an innate desire to conform or accept views of those with whom they identify. This makes for agreement with, and acceptance by, others. It is easier to conform than to resist the values of the group. Hence comes the tendency to behave and believe as the group does—and the tendency to reject or resist information contradicting the group opinion. These largely subconscious phenomena become fixed personality traits—usually resistant to reason. This craving for security impels the individual to have an attitude on any decisive issue and requires that this attitude be of a stability corresponding

to the nature of the situation to which it refers. The individual then protects this attitude from being undermined by thought or perception processes.[15]

Goldberg supports this premise with his hypothesis that, when factual answers cannot be found or when the answers pose a threat to emotional security, an individual fabricates answers and distorts information so as to reinforce the attitude he has already established, whether conscious or not.[16] Prejudice within the individual may manifest itself differently in private life than in the group—because of the need for group identification.

Although among social scientists concepts differ concerning formation of attitude, they have certain points of agreement: attitudes are not inherited; the learning process plays a major role in their development; attitudes involve problems of perception and motivation; people may act contrary to their attitudes.[17]

*Stability of Attitudes.*—It has been proved and generally accepted that certain attitudes within the individual change. Attitudes toward product preferences, politics, style in clothing, unemployment, labor unions, and the like can and do change quite readily.

Agreement is less conclusive in the area of change of social attitude in religious and ethnic prejudices, particularly where minority groups are involved and the prejudice is negative, that is, where the attitude serves to place the object of the attitude at a disadvantage. Prejudicial attitudes of this nature, though always modifiable, are much more resistant to fundamental change.

Prejudice toward minority groups is a complex phenomenon. Authorities who have studied the problem[18, 19, 20] recognize such contradictions as: group hostility thriving very well alongside friendly, even intimate relations between individuals of two hostile groups—the accepted individual being considered an exception to his group; persistence of prejudice in the face of contradictory facts and radically altered social situations; and, in some instances, reversal of modified attitudes to their original form—people whose behavior has been changed through psychological manipulation lapse into old ways as soon as the agencies of manipulation are removed.

*Modification of Attitudes.*—Social scientists agree, and the results of studies corroborate, that a number of ways are effective in changing public attitudes as they relate to the minority group described as the "handicapped." The most effective is through intergroup contact or interaction. When prejudiced people are brought into direct contact with minority group members and share experiences with them, attitudes often undergo a gradual but deep change. Familiarity with the attitude stimulus diminishes unconscious fear of the unknown, since such fears are often unfounded and based on ignorance. The closer the relationship between the handicapped and others, the greater the potency of such relationships in the formation or change of attitudes.[3]

Direct educational programs are a second way of changing attitudes. Familiarization with accurate information can contribute directly to an amelioration of the cultural atmosphere in which undesirable attitudes breed. Again, this tends to dissipate fear of the unknown or the uncertain.

A third way is through changing the attitudinal environment of the prejudiced individual. As stated earlier, people desire to accept the views of those with whom they identify. A person seeing others around him changing their attitudes is relieved of vague fears and can change with them. If, therefore, a prejudiced person is in a situation where people important to him are free of prejudice and express this, he may change without being aware of it.[21] Thus, people who enjoy prestige in the eyes of the conformist can effect a change, particularly if their statements are backed by action and not contradicted by other people of high prestige.

While contacts that provide knowledge and acquaintance engender sound beliefs and hence contribute to reducing prejudice, the effect of the contact depends upon the kind of association involved. True acquaintance tends to lessen prejudice. The more sustained the acquaintance, the less the prejudice. Those having closer contact perceive less difference than those who are farther away. On the other hand, casual contact may leave matters worse if participants are motivated to associate with the handicapped for such unrealistic reasons as sympathy or vague fears. Only the type of contact that leads people to *do* things together is likely to bring about positive results.[20] The acceptance of the handicapped is greater in war-torn countries where the physically maimed are seen in greater numbers and enter into the social life more than they do in North America.

Legislation against discrimination is another possible device but is probably only indirectly effective in that it creates an atmosphere discouraging the development or practice of prejudice. Laws, however, can create situations that stimulate change in existing prejudices or discrimination.

Psychotherapy is yet another way of effecting change in attitudes. While this is an important individual approach, it is not, at least currently, adaptable to large-scale operations.

### Experimental Studies Relating to Change in Attitude

By comparison with research relating to attitudes toward ethnic and religious groups, relatively few studies have been reported that attempted specifically to measure change in attitude toward the handicapped.

Kvaraceus[23] investigated the attitude (acceptability) of professional workers—mostly teachers—toward various disabling conditions in relation to their knowledge of the

conditions. Results revealed a strong preference of the respondents for teaching those groups of disabled about whom they believed themselves best informed.

McBride[24] measured attitudes of the public toward epileptics relative to attitudes toward other disabilities. An experimental group was given information on epilepsy, but the results were not significantly conclusive. Granofsky[25] conducted a controlled before-and-after experiment attempting to change underlying attitudes of the nondisabled toward disabled war veterans by an induced social contact experience. Again results were inconclusive. The authors of the latter two studies imply that the indecisive results may be due to the nature of the sample selection and the measuring tools used.

This writer conducted an extensive investigation to measure differences in attitude according to extent of accurate information held about, and degree of personal contact with, disabled persons.[26] Findings revealed significant mean attitude score differences among groups. The principal conclusions were that social contact between the nondisabled and disabled and increased factual knowledge of the disabled lead to a more generalized tolerance and fundamental acceptance of handicapped persons.

### Practical Implications to Rehabilitation Workers and Agencies

If, as the dominant conclusions suggest, the essential ingredient in modifying social attitudes is interaction of disabled and nondisabled, what practical implication does this have for the professional agency and rehabilitation worker?

For the rehabilitation agency this points to active, direct participation by the public in rehabilitation programs. Paradoxically, rehabilitation programs have tended to disassociate the public (especially the volunteer) from the client. There seems to be mounting resistance to use of volunteers in direct program function and a seemingly dogmatic intolerance of their participation on the part of professional workers. Increasingly, volunteers are relegated to the sole function of fund raising and like tasks that isolate them from the client. The rationale behind this resistance is that volunteers, though with good intentions, disrupt programing and cause undue psychological trauma to the client. This argument is too often exaggerated—merely reflecting a deterioration in the art of professional leadership in use of volunteers. Organizations that properly screen, orient, and supervise volunteers attest to the value of volunteer programs, even to involvement in very direct treatment or program situations. The benefits to be gained from more direct lay participation far exceed the limitations. Such a sound volunteer program is not developed without cost and effort. Its success depends on the allocation of adequate funds and assignment of qualified, competent staff.

Some agencies have been eminently successful in mobilizing the lay public and assimilating their activities into rehabilitation programs. The volunteer visiting programs to mental hospitals have been a deliberate attempt by organizations to change the social climate for the posttreatment psychiatric patient. Such groups are cognizant of the relative futility of psychotherapy in the face of rejecting public attitudes. Other agencies assign volunteers to "staff" functions, as in camping and regular recreational activities. Too frequently, however, activities relegated to the volunteer include showering sympathy on the handicapped by providing gifts or delicacies for a party. The atmosphere of such activity serves only to reinforce the existing negative attitude stereotype, as against the other approach in which the volunteer is placed in a setting that makes demands on him to treat the handicapped in a manner consistent with agency principles of treatment. In the latter instance, the effect is a modification of attitudes within the agency's corps of volunteers, manifested not on a one-to-one basis but in terms of geometric progression. The modified attitude of one individual influences his family and friends, who in turn influence others in a rapidly multiplying fashion.

The professional rehabilitation worker, then, must avoid the tendency to isolate himself and his work activities from the public. The clinical environment of the rehabilitation setting must expand to include actively more facets of community life. The public can be involved in a variety of ways, limited only by the imagination, resourcefulness, and desire of agencies. Planning and developing programs utilizing resources for normal persons is one approach. This is in contrast to the recent trend of building special and isolated facilities—a situation that would have developed in a more balanced manner had the problems of the handicapped been envisaged in total perspective. If the adult handicapped is expected to live in a normal environment, he should, to the extent possible, be conditioned during his formative period in such a setting. By analogy, society also needs an opportunity to learn to accept and adjust to the situation.

Finally, rehabilitation organizations must protect against undermining the constructive results of their program efforts. Voluntary agencies are in danger of allowing fund-appeal publicity to contradict the philosophy and efforts of their treatment programs. Agencies must resist the pressures of the promotion man, fund-raising director, or service clubs to use stereotyped "tear-jerking" pictures and slogans as the media for extracting public financial support. Granted, pressures are tremendous on an agency to resort to such a device—competition from other appeals, cost of campaigns, the fact that the device is so simple to employ and that good results can be obtained despite weak organizational structure. Good and adequate results can and are being obtained without these devices by agen-

to the nature of the situation to which it refers. The individual then protects this attitude from being undermined by thought or perception processes.[15]

Goldberg supports this premise with his hypothesis that, when factual answers cannot be found or when the answers pose a threat to emotional security, an individual fabricates answers and distorts information so as to reinforce the attitude he has already established, whether conscious or not.[16] Prejudice within the individual may manifest itself differently in private life than in the group—because of the need for group identification.

Although among social scientists concepts differ concerning formation of attitude, they have certain points of agreement: attitudes are not inherited; the learning process plays a major role in their development; attitudes involve problems of perception and motivation; people may act contrary to their attitudes.[17]

*Stability of Attitudes.*—It has been proved and generally accepted that certain attitudes within the individual change. Attitudes toward product preferences, politics, style in clothing, unemployment, labor unions, and the like can and do change quite readily.

Agreement is less conclusive in the area of change of social attitude in religious and ethnic prejudices, particularly where minority groups are involved and the prejudice is negative, that is, where the attitude serves to place the object of the attitude at a disadvantage. Prejudicial attitudes of this nature, though always modifiable, are much more resistant to fundamental change.

Prejudice toward minority groups is a complex phenomenon. Authorities who have studied the problem[18, 19, 20] recognize such contradictions as: group hostility thriving very well alongside friendly, even intimate relations between individuals of two hostile groups—the accepted individual being considered an exception to his group; persistence of prejudice in the face of contradictory facts and radically altered social situations; and, in some instances, reversal of modified attitudes to their original form—people whose behavior has been changed through psychological manipulation lapse into old ways as soon as the agencies of manipulation are removed.

*Modification of Attitudes.*—Social scientists agree, and the results of studies corroborate, that a number of ways are effective in changing public attitudes as they relate to the minority group described as the "handicapped." The most effective is through intergroup contact or interaction. When prejudiced people are brought into direct contact with minority group members and share experiences with them, attitudes often undergo a gradual but deep change. Familiarity with the attitude stimulus diminishes unconscious fear of the unknown, since such fears are often unfounded and based on ignorance. The closer the relationship between the handicapped and others, the greater the potency of such relationships in the formation or change of attitudes.[3]

Direct educational programs are a second way of changing attitudes. Familiarization with accurate information can contribute directly to an amelioration of the cultural atmosphere in which undesirable attitudes breed. Again, this tends to dissipate fear of the unknown or the uncertain.

A third way is through changing the attitudinal environment of the prejudiced individual. As stated earlier, people desire to accept the views of those with whom they identify. A person seeing others around him changing their attitudes is relieved of vague fears and can change with them. If, therefore, a prejudiced person is in a situation where people important to him are free of prejudice and express this, he may change without being aware of it.[21] Thus, people who enjoy prestige in the eyes of the conformist can effect a change, particularly if their statements are backed by action and not contradicted by other people of high prestige.

While contacts that provide knowledge and acquaintance engender sound beliefs and hence contribute to reducing prejudice, the effect of the contact depends upon the kind of association involved. True acquaintance tends to lessen prejudice. The more sustained the acquaintance, the less the prejudice. Those having closer contact perceive less difference than those who are farther away. On the other hand, casual contact may leave matters worse if participants are motivated to associate with the handicapped for such unrealistic reasons as sympathy or vague fears. Only the type of contact that leads people to *do* things together is likely to bring about positive results.[20] The acceptance of the handicapped is greater in war-torn countries where the physically maimed are seen in greater numbers and enter into the social life more than they do in North America.

Legislation against discrimination is another possible device but is probably only indirectly effective in that it creates an atmosphere discouraging the development or practice of prejudice. Laws, however, can create situations that stimulate change in existing prejudices or discrimination.

Psychotherapy is yet another way of effecting change in attitudes. While this is an important individual approach, it is not, at least currently, adaptable to large-scale operations.

## Experimental Studies Relating to Change in Attitude

By comparison with research relating to attitudes toward ethnic and religious groups, relatively few studies have been reported that attempted specifically to measure change in attitude toward the handicapped.

Kvaraceus[23] investigated the attitude (acceptability) of professional workers—mostly teachers—toward various disabling conditions in relation to their knowledge of the

conditions. Results revealed a strong preference of the respondents for teaching those groups of disabled about whom they believed themselves best informed.

McBride[24] measured attitudes of the public toward epileptics relative to attitudes toward other disabilities. An experimental group was given information on epilepsy, but the results were not significantly conclusive. Granofsky[25] conducted a controlled before-and-after experiment attempting to change underlying attitudes of the nondisabled toward disabled war veterans by an induced social contact experience. Again results were inconclusive. The authors of the latter two studies imply that the indecisive results may be due to the nature of the sample selection and the measuring tools used.

This writer conducted an extensive investigation to measure differences in attitude according to extent of accurate information held about, and degree of personal contact with, disabled persons.[26] Findings revealed significant mean attitude score differences among groups. The principal conclusions were that social contact between the nondisabled and disabled and increased factual knowledge of the disabled lead to a more generalized tolerance and fundamental acceptance of handicapped persons.

### Practical Implications to Rehabilitation Workers and Agencies

If, as the dominant conclusions suggest, the essential ingredient in modifying social attitudes is interaction of disabled and nondisabled, what practical implication does this have for the professional agency and rehabilitation worker?

For the rehabilitation agency this points to active, direct participation by the public in rehabilitation programs. Paradoxically, rehabilitation programs have tended to disassociate the public (especially the volunteer) from the client. There seems to be mounting resistance to use of volunteers in direct program function and a seemingly dogmatic intolerance of their participation on the part of professional workers. Increasingly, volunteers are relegated to the sole function of fund raising and like tasks that isolate them from the client. The rationale behind this resistance is that volunteers, though with good intentions, disrupt programing and cause undue psychological trauma to the client. This argument is too often exaggerated—merely reflecting a deterioration in the art of professional leadership in use of volunteers. Organizations that properly screen, orient, and supervise volunteers attest to the value of volunteer programs, even to involvement in very direct treatment or program situations. The benefits to be gained from more direct lay participation far exceed the limitations. Such a sound volunteer program is not developed without cost and effort. Its success depends on the allocation of adequate funds and assignment of qualified, competent staff.

Some agencies have been eminently successful in mobilizing the lay public and assimilating their activities into rehabilitation programs. The volunteer visiting programs to mental hospitals have been a deliberate attempt by organizations to change the social climate for the posttreatment psychiatric patient. Such groups are cognizant of the relative futility of psychotherapy in the face of rejecting public attitudes. Other agencies assign volunteers to "staff" functions, as in camping and regular recreational activities. Too frequently, however, activities relegated to the volunteer include showering sympathy on the handicapped by providing gifts or delicacies for a party. The atmosphere of such activity serves only to reinforce the existing negative attitude stereotype, as against the other approach in which the volunteer is placed in a setting that makes demands on him to treat the handicapped in a manner consistent with agency principles of treatment. In the latter instance, the effect is a modification of attitudes within the agency's corps of volunteers, manifested not on a one-to-one basis but in terms of geometric progression. The modified attitude of one individual influences his family and friends, who in turn influence others in a rapidly multiplying fashion.

The professional rehabilitation worker, then, must avoid the tendency to isolate himself and his work activities from the public. The clinical environment of the rehabilitation setting must expand to include actively more facets of community life. The public can be involved in a variety of ways, limited only by the imagination, resourcefulness, and desire of agencies. Planning and developing programs utilizing resources for normal persons is one approach. This is in contrast to the recent trend of building special and isolated facilities—a situation that would have developed in a more balanced manner had the problems of the handicapped been envisaged in total perspective. If the adult handicapped is expected to live in a normal environment, he should, to the extent possible, be conditioned during his formative period in such a setting. By analogy, society also needs an opportunity to learn to accept and adjust to the situation.

Finally, rehabilitation organizations must protect against undermining the constructive results of their program efforts. Voluntary agencies are in danger of allowing fund-appeal publicity to contradict the philosophy and efforts of their treatment programs. Agencies must resist the pressures of the promotion man, fund-raising director, or service clubs to use stereotyped "tear-jerking" pictures and slogans as the media for extracting public financial support. Granted, pressures are tremendous on an agency to resort to such a device—competition from other appeals, cost of campaigns, the fact that the device is so simple to employ and that good results can be obtained despite weak organizational structure. Good and adequate results can and are being obtained without these devices by agen-

cies concentrating on strong community programs, using its volunteer work force in a constructive manner during fund-raising periods.

These comments should not be construed as an attempt to oversimplify the problem, or rather the solution. The issues involved in attitudes of society are extremely complex regarding the disabled and shifts in technic and agency programing must, of necessity, be gradual. This is an area that rehabilitation organizations, particularly voluntary, should seriously consider as presenting a major unmet need and as a challenge in the coming decade.

With the rapid growth of physical rehabilitation resources and with official government agencies assuming more and more responsibility for the financial operation of services, private agencies are increasingly being relieved of much financial and program responsibility. This means a gradual shift in program for many agencies, leaving funds available for evaluation of unmet needs and research into technics to combat unsolved problems. High priority should be given the surmounting of psychosocial barriers confronting the handicapped.

## References


1. Tenny, J. W., The Minority Status of the Handicapped. *Exceptional Children,* April, 1953. 19:7:260-264.
2. Rawls, H. D., Social Factors in Disability. *New Outlook for the Blind,* June, 1957. 51:6:231-236.
3. Remmers, H. H., Social Attitudes, *in:* Fryer, D. H., and Henry, E. R., *Handbook of Applied Psychology.* New York and Toronto: Rinehart, 1950. p. 10-13.
4. Berreman, J. V., Some Implications of Research in the Social Psychology of Physical Disability. *Exceptional Children,* May, 1954. 20:8:347-350, 356-357.
5. Hentig, Hans von, Physical Disability, Mental Conflict and Social Crisis. *J. Social Issues,* Fall, 1948. 4:4:21-27.
6. Cruickshank, W. M., The Impact of Physical Disability on Social Adjustment. *J. Social Issues,* Fall, 1948. 4:4: 78-83.
7. Force, D. G., Jr., Social Status of Physically Handicapped Children. *Exceptional Children,* Dec., 1956. 23:3: 104-107, 132. (Summary of unpublished doctoral dissertation, University of Michigan, 1954)
8. Barker, R. G., Wright, B. A., Meyerson, L., and Gonick, M. R., *Adjustment to Physical Handicap and Illness: A Survey of the Social Psychology of Physique and Disability.* New York: Social Science Research Council, 1953. *(Bul. 55, Rev. 1953)*
9. Bender, L., and Silver, A., Body Image Problems of the Brain Damaged Child. *J. Social Issues,* Fall, 1948. 4:4:84-89.
10. Sullivan, J. D., Psychiatric Problems in Young Adult Cerebral Palsied Patients. *Diseases Nerv. System,* Aug., 1956. 17:8:243-248.
11. Fielding, B. B., The Rehabilitation Process and the Status of the Disabled in the Community. *Exceptional Children,* March, 1953. 19:6:228-230, 232-233.
12. Kessler, H. H., *The Crippled and the Disabled.* New York: Columbia University Pr., 1935.
13. Hanks, J. R., and Hanks, L. M., Jr., The Physically Handicapped in Certain Non-Occidental Societies. *J. Social Issues,* Fall, 1948. 4:4:11-20.
14. McNemar, Q., Opinion-Attitude Methodology. *Psych. Bul.,* July, 1946. 43:4:289-374.
15. Cobliner, W. G., On the Place of Projective Tests in Opinion and Attitude Surveys. *Internatl. J. Opinion and Attitude Res.,* Winter, 1951-52. 5:480-490.
16. Goldberg, I. I., Teachers College, Columbia University. (Correspondence, Sept., 1957)
17. Chein, I., Behavior Theory and the Behavior of Attitudes: Some Critical Comments. *Psych. Rev.,* May, 1948. 55:3:175-188.
18. Bettelheim, B., and Janowitz, M., *Dynamics of Prejudice.* New York: Harper, 1950.
19. Adorno, T. W., Frenkel-Brunswik, Else, Levinson, D. F., and Sanford, R. N., *The Authoritarian Personality.* New York: Harper, 1950.
20. Eysenck, H. J., *Uses and Abuses of Psychology.* Baltimore: Penguin, 1953.
21. Jahoda, Marie, What Is Prejudice? *Look,* May 24, 1960. 24:11:93-94+.
22. Allport, G. W., *The Nature of Prejudice.* Reading, Mass.: Addison-Wesley Company, 1954.
23. Kvaraceus, W. C., Acceptance-Rejection and Exceptionality. *Exceptional Children,* May, 1956. 22:8:328-331.
24. McBride, Elsa T., *Social Acceptance of the Disabled and the Influence of the Film* Seizures *on Expressed Attitudes Toward Epileptics.* Master's thesis, University of Tennessee, 1954.
25. Granofsky, J., *Modification of Attitudes Toward the Visibly Disabled.* Doctoral dissertation, Yeshiva University, 1955. *In:Dissertation Abstracts,* 1956. 16:1182-1183.
26. Roeher, G. A., *A Study of Certain Public Attitudes Toward the Orthopaedically Disabled.* Doctoral dissertation, New York University, 1959.

# TOWER

# *Testing, Orientation and Work Evaluation In Rehabilitation*

***Written and published by the Institute for the Crippled and Disabled, 400 First Avenue, New York 10, New York. 1959. 131 p. illus., forms. $4.95.***

**Reviewed by William G. Gellman, Ph.D.**

THE INSTITUTE FOR THE CRIPPLED AND DISABLED summarizes in *TOWER* the theory and methodology of the TOWER System, which uses work samples to appraise the vocational potential of disabled persons. The acceptance and utilization of the TOWER System by rehabilitation centers throughout the country is a striking testimonial to the Institute's emphasis upon the importance of the vocational component in rehabilitation. The emergence of the TOWER System as a major technic of vocational rehabilitation is a measure of the Institute's contribution to the field of vocational rehabilitation under the leadership of the late Willis C. Gorthy.

The presentation of the TOWER System is divided into two parts. Section I discusses the role of vocational evaluation in rehabilitation, the rationale for the work sample technic, and the development of the TOWER System from its beginnings in 1936 as an improved method of preparing disabled persons for lower-level jobs. Section II provides background information for installing and applying the TOWER System. It deals with such aspects as physical plant, organization, administration, rating client performance, and record keeping. An inclusive bibliography adds to the value of the volume for readers.

The Institute developed the TOWER System to expand job horizons and employment possibilities for handicapped persons. The current version of the TOWER System incorporates three phases of the Institute's work with disabled persons: 1) placement in industry, 2) selection for training in semiskilled, skilled, unskilled, or clerical occupations, and 3) determination of the degree of employability. The appraisal of vocational potential, the present stage, involves decision in each of these areas. The job-sample method is described as usable with clients who

**About the Reviewer . . .**

*Dr. Gellman is executive director of the Jewish Vocational Service, Chicago, and director of the Easter Seal Research Foundation of the National Society for Crippled Children and Adults. His training (at Columbia, New York University, and the University of Chicago) and experience are in the fields of social work and psychology with primary emphasis on rehabilitation, work adjustment of the handicapped, and vocational guidance. Dr. Gellman is a recipient of the W. T. Faulkes Award of the National Rehabilitation Association for technical competence in rehabilitation. He is chairman of the Chicago Area Chapter of the National Association of Social Workers and president of the Illinois Rehabilitation Association. Dr. Gellman was a delegate to the 1961 International Social Work Conference in Rome, acting as a consultant. He serves on the training committee of the U.S. Office of Vocational Rehabilitation, on the Adult Advisory Rehabilitation Services of the Veterans Administration, and on the board of directors of the National Rehabilitation Association. He is also a member of the American Psychological Association, the American Personnel and Guidance Association, and the National Association of Social Workers.*

are unable to speak English or who lack work experience and as being particularly adapted for two groups of disabled persons:

1) those who, because of a lack of education or the absence of a suitable cultural background, cannot adequately demonstrate their vocational potential through standardized test batteries, and 2) those whose physical or emotional disabilities are such that other evaluation means might fail to reveal their occupational potential. *(p. 20)*

The TOWER System is distinguished from other situational technics of vocational evaluations by the use of discrete task duplicating all or part of an industrial operation. It differs from standardized performance tests in the flexibility of instructions and the utilization of a test setting designed to resemble a workshop. The tests consist of a series of increasingly difficult problems involving the use of tools or the performance of industrial operations in each of 13 job fields. Three weeks are usually required for testing in all 13 categories of the TOWER System. Scores are based upon quality and performance rate. The evaluator also rates the client's interest in various tasks and such items as dexterity, work tolerance, work habits, and acceptance of instruction. An over-all judgment of client performance identifies the type of skilled, semiskilled, and unskilled activities he can undertake in clerical, service, or industrial fields.

The determination of vocational potential takes into account work performance and personal characteristics such as attitudes, appearance, and interpersonal relationships. The objective of the TOWER System is to contribute a realistic appraisal of a client's occupational potential to the assessment of the disabled person as a whole by the rehabilitation team. In practice, the primary purpose is the selection of an occupational goal for each client that is within the range of his abilities and available in the locality. A secondary purpose is corroboration or extension of the counselor's judgment of client aptitudes or interest, adding a dimensional quality to interviewing.

Studies supporting the TOWER System's accuracy compare the evaluation prognosis based upon the work sample technic with placement experience or the supervisor's rating in an Institute training course. The text states, "Of a total of 534 clients recommended for a specific job area by the evaluator, 132 were referred for direct placement immediately following evaluation, while 402 were referred for training" *(p. 57)*. Two tables *(p. 59)* indicate that a high percentage of both groups were successfully placed and that persons who received a TOWER System rating of "superior" were also rated as "superior" by the instructor in the training program. The supporting data are meager and susceptible to varying interpretations. Fiske in his discussion of situational technics in prevocational appraisal says:

The book [*TOWER*] outlining this approach is, from a technical viewpoint, disappointing with respect to evidence on the empirical validation of its tests. It gives data on percentages of tested clients who were successfully placed, but has no comparison figures by which one can estimate the contribution of the testing. It also provides figures on the agreement between the evaluator and the training instructor, but these also cannot be appraised without additional data—in this case, the actual evaluations on all other clients. *(p. 19)*

The statistical deficiencies in the validation evidence are transitory. Future editions of *TOWER* will report the results of more precise follow-up and experimentation. However, even improved statistical technics may not overcome the limits inherent in the work-sample approach to vocational evaluation. Moed's excellent discussion of methods of prevocational appraisal presents the following rationale for the TOWER System:

The work sample, as you all know, has its value in that it is directly related to the vocational activity from which it is drawn. As a predictor of vocational potential, the work sample gives the evaluator an opportunity to compare the handicapped client with the performance of a successfully employed person. *(p. 2)*

The assumptions underlying the conceptual framework of the TOWER System as a predictive device merit formulation and discussion. Five appear to be significant:

1) A task or a series of discrete operations duplicates a job in industry.

> An industrial job is more than a series of related tasks. It is a gestalt involving psychosocial components, interpersonal relations as well as physical duties. The individual task or operations when abstracted from the work setting bear no closer relations to the reality of a job in industry than the scores on a standardized performance test.

2) A group of work samples simulate the reality of work.

> This assumption raises a number of questions. Can testing with job samples in a work setting reproduce a work situation? Are there elements in work that go beyond the performance of a series of physical duties? Does the use of job samples or the prolongation of the testing period add a touch of realism or a note of reality? If one accepts a wider definition of work than that proposed in the TOWER System, is the testing situation reality testing? On general balance, one would conclude that the group of work tasks used as a testing mechanism are neither more nor less real than any other form of psychological testing. To determine whether a given client considers the TOWER System of testing as "real work" requires prior knowledge of the meaning of work to such client.

3) "If the range of the work samples is large and representative of jobs found in the community, theoretically

it should be possible to determine a client's employability with reasonable success." *(Moed, p. 2)*

> Fiske's comment is pertinent:
>
> The biggest problem with this approach is the impossibility of having tests for all, or even most, types of work. For the foreseeable future, it will usually be necessary to infer, on the basis of face validity, that performance on one test is pertinent to performance in a particular job. Such validity is often called faith validity, and with some reason! *(p. 20)*

4) "The work sample technique is also used for making recommendations concerning a client's ability to perform a job that is related to, but not exactly duplicated by, the sample in the unit." *(Moed, p. 3)*

> In discussing this assumption, Moed states:
>
> The rationale, of course, is that operations in related trades require similar mental ability, dexterity, skills and/or tool usage. It is probably reasonable to assume that the closer the related job is to the one the sample duplicates, the better will be the basis for the recommendation. Exactly how good, is still an unanswered question. *(p. 4)*

5) The work sample permits determination of the feasibility of training a client to his highest skill level.

> This assumption is probably valid. Both verbal and performance tests are reasonably successful in selecting students for training courses. Whether the TOWER System predicts the degree of the success or future levels of work performance is still open to question. Moed states, "Skill level predictions are at best difficult, and should be validated through follow-up studies as soon as an experimental population is obtainable" *(p. 3)*. As yet there are no follow-up studies that compare the level of functioning originally predicted by the work sample with the level achieved by the person after he has been on the job for a specific period.

Despite paucity of validation data and theoretical objections to the work-sample approach exemplified in the TOWER System, the philosophy and concept of an activity-based vocational evaluation program complementing vocational counseling is a valuable corrective to rehabilitation center attitudes that depreciate the importance of work and see work problems as secondary. The TOWER System provides concrete evidence that vocational evaluation can provide service to disabled individuals whose vocational potential cannot be assessed through conventional counseling technics. It points up the possibility that work and purposeful activity can serve as therapeutic tools.

Equally important to rehabilitation centers is the use of the work sample technic as a preplacement procedure or as a selection device for training courses. If a center maintains training programs in semiskilled or skilled trades or has access to such programs, the TOWER System provides preliminary vestibule training. If course content and criteria are known, the testing period serves to eliminate individuals who cannot benefit from training. In such cases its chief function is that of rejecting disabled persons who do not meet minimum criteria for the training program.

The most important function of the TOWER System in a rehabilitation center is the selection and preparation of disabled persons for specific jobs in industry. Its use for this purpose reflects the importance of the first stage of development of the TOWER System when placement of disabled persons was all important for the Institute. The conceptual framework for the use of the TOWER System as a preplacement technic may be summarized as follows: If an agency knows which jobs are available and open to disabled persons, it can replicate such jobs in a workshop setting and use the workshop replication to test and prepare clients for the industrial job. Disabled persons trained on the workshop job should have a better opportunity for placement and be able to function at a relatively higher level in industry.

Job replication in an operating workshop is a useful placement procedure if two conditions are met: 1) a close relationship between the agency and industrial firms that offers trained clients access to selected jobs and 2) the agency directs clients toward jobs so available. The technic has limited applicability if the preceding conditions are not met or if the replicated jobs are not available in the community. The latter may occur if communities outside New York adopt the TOWER System without adapting the work samples to the local situation.

The ambiguous relationship between the TOWER System and vocational counseling poses problems for rehabilitation centers. The explicit separation between vocational evaluation using work samples and vocational counseling using interviews negates the emphasis in Section I of TOWER upon the meaning of work to the individual client. It leaves to the staffing conference of the rehabilitation center the difficult task of reconciling two different views of the disabled person as a working, functioning being. Integrating these viewpoints throughout the rehabilitation process would provide the vocational counselor with material to amplify interview insights and the vocational evaluation with the dynamics of personality that add depth to behavioral observations. The dilemma can be resolved if vocational evaluation is treated as part of vocational counseling rather than as a separate entity, and the TOWER System as a technical tool rather than an end in itself.

This implies the use of vocational counselors as evaluators, a flexible approach to evaluation programing based upon counseling material for each client, greater attention to the influence of motivational and attitudinal factors in work life, a broader conception of the work role, and unification of the workshop and work-sample approaches.

Extending the scope of the TOWER System to include the dynamics of vocational choice and adjustment would help eliminate the Procrustean fallacy of fitting the disabled person to training courses or jobs available at or through the rehabilitation center. It would carry to its logical conclusion the Institute's objective of expanding job horizons for disabled persons.

TOWER adds to the literature of rehabilitation a systematic presentation of an activity-based method of vocational evaluation for rehabilitation center clients. Although the technic, the TOWER System, is limited in scope and requires expansion and modification, the background statement, Section I, incorporating the pioneering concepts of Gorthy, Garrett, and Usdane, is a permanent contribution to the rehabilitation field. The book merits the attention of rehabilitation personnel who consider the use of situational or life technics a necessary corrective for the unidimensional quality characterizing rehabilitation staffings and the functioning of rehabilitation disciplines.

### References

Moed, Martin G. Procedures and Practices in Pre-Vocational Evaluation: A Review of Current Programs. *In* College of Education, State University of Iowa: *Proceedings of the Iowa Conference on Pre-Vocational Activities at Iowa City, Iowa, April 19-21, 1960,* John E. Muthard, ed., p. 1-12. Iowa City, Iowa, The College, 1960. 78 p.

Fiske, Donald W. Procedures and Practices in Pre-Vocational Evaluation: Problems in Measuring Capacity and Performance. *Ibid.*, p. 13-27.

## Other Books Reviewed

158

**The Central Nervous System and Behavior; Selected Translations from the Russian Medical Literature**

Prepared by: **U.S. Public Health Service**

1959. 1051 p. figs., tabs. Multilithed. Loose-leaf. Prepared and distributed by the Russian Scientific Translation Program, National Institutes of Health, Bethesda, Md.

THE 70 TRANSLATED ARTICLES collected for participants of the Third Macy Conference on the Central Nervous System and Behavior, held at Princeton, N.J., Feb. 21-24, 1960, are representative of research in the related fields of neurosurgery, physiology, psychology, and psychiatry. In the field of speech development, for example, there are three articles by A. R. Luria, as well as an article by B. E. Sheivekhman on "Methods of Fixing Speech Habits Developed in Deaf-Mute Children Practically Deprived of Hearing." Since these articles are not normally available to American scientists unable to read the Russian language, the National Institutes of Health is distributing copies of the collection to medical libraries throughout the United States and Canada.

159

**Chronic Disease Control**

By: **University of Michigan School of Public Health, Continued Education Service**

1960. 211 p. tabs. Paperbound. Distributed by Continued Education Service, University of Michigan School of Public Health, 109 S. Observatory St., Ann Arbor, Mich. $3.00.

REPRESENTING A COMPILATION of 39 papers presented at the Institute on Chronic Disease Control, conducted by the Department of Public Health Practice, University of Michigan School of Public Health, in June, 1960, the book offers a review of current chronic disease public health programing and suggests new approaches to chronic disease control. Participating in the Institute were physicians and nurses in the field of public health, nutritionists, and health educators involved in planning and administering chronic disease programs at the state or local level. Broad subjects covered included prevention or early detection of diseases causing chronic illness or disability, community screening programs, public welfare medical programs, home care and homemaker services, hospital and nursing home care of chronically ill patients, and community rehabilitation programs. Dr. Dean W. Roberts contributed a paper on "Organization of rehabilitation services" (p. 181-184). Health needs of the aging and aged were emphasized.

160

**Delinquent and Neurotic Children; A Comparative Study**

By: **Ivy Bennett, M.A., Ph.D.**

1960. 532 p. tabs. Basic Books, Inc., 59 Fourth Ave., New York 3, N.Y. $10.00.

FROM ANALYSIS of the detailed case histories of 100 boys and girls whom she studied over a 3-year period while they were receiving treatment at child guidance clinics, Dr. Bennett cites pertinent evidence favoring the theory that different patterns of inter-relationships within the family and of personality structure do exist to account for delinquent behavior or less dramatic "neurotic" symptoms. Part I contains a discussion of the background and plan for the research project; Part II discusses results and findings of the research in regard to characteristics of delinquent and neurotic behavior and the frequency of

their appearance, social and environmental conditions of the children and their families, development of the children, and their personal and educational experiences. Dr. Bennett does not claim that these family patterns and conditions associated with delinquency or neurotic behavior are the *cause* of such disorders; all that has been shown is that certain factors tend to occur together with certain types of behavior. Part III contains the case history summaries; statistical data are given in the appendix. A 14-page bibliography and a subject index are additional features. Findings in regard to incidence of chronic illness, physical disability, or accidental injury were studied for their possible contribution to delinquent behavior (p. 171-172). Results tended to confirm those of earlier studies—that there is little evidence to show such factors contribute specifically to delinquency rather than to other forms of childhood maladjustment. Dr. Bennett is a psychologist and psychoanalyst who has practiced for the past 10 years in London.

161

**Fünfundzwanzigste Konferenz des Verbandes der Deutschen Evangelischen Anstalten für Körperbehinderte . . . April 24-26, 1960**

By: **Association of German Protestant Institutions for the Disabled**

1960. 144 p. illus., tabs. Paperbound. Verbandes der Deutschen Evangelischen, Annastift e.V. Orthopädische Heil- und Lehranstalt, Hannover-Kleefeld, Germany.

PROCEEDINGS OF THE 25th Conference of the Association of German Protestant Institutions for the Disabled commemorate the 60th anniversary of the organization; work of the Association during the period is reviewed. Papers and discussions covered such subjects as paralysis as viewed by the physician, recreation services in Association institutions, use of occupational therapy, the role of sheltered workshops in rehabilitation, church communities' responsibility for maintaining the institutions, work for bedridden patients, the profitability of training workshops, and evaluation of work skills in industry.

162

**Manual of Care for the Disabled Patient**

By: **Arthur J. Heather,** M.D.

1960. 119 p. figs. The Macmillan Co., 60 Fifth Ave., New York 11, N.Y. $3.75

EFFECTIVE PREVENTIVE and therapeutic measures to combat complications that often develop in patients with hemiplegia, paraplegia, quadriplegia, forms of arthritis, or neurological diseases are outlined briefly; the rationale underlying each step in the program is explained. Among subjects discussed are bowel training, proper bed positioning of the patient, simple measures to maintain range of motion in joints, nutrition, prevention and treatment of decubitus ulcers, urinary tract complications, and the prevention of muscle contractures and joint ankyloses. Chapter 10 (p. 77-104) contains a recommended rehabilitation program for amputees, with a discussion of prostheses for the lower extremity. The book contains a bibliography and a subject index. It should be most useful in orienting medical and nursing personnel of general hospitals to problems in caring for such patients. Illustrations add considerably to the book's value.

163

**Music Therapy 1959; Ninth Book of Proceedings of the National Association for Music Therapy . . . Papers from the Tenth Annual Conference, East Lansing, Michigan. . . .**

Edited by: **Erwin H. Schneider,** Ph.D. (Associate editors: **Ruth Boxberger** and **William W. Sears,** Ph.D.)

1960. 250 p. tabs. The Allen Press, Lawrence, Kan. $5.20.

PAPERS AT THE Tenth Conference of the Association, held at Michigan State University in October, 1959, discussed concepts and uses of music in therapeutic settings, specific music therapy technics, and current research. Part I covers music therapy in mental hospitals; Part II, the use of volunteers in music therapy programs; Part III (p. 81-90), music therapy for exceptional children; Part IV, music therapy and music education; Part V, music therapy in geriatrics; Part VI, special conference reports; Part VII, research in music therapy; and Part VIII, reports of regional chapters of the Association. Articles in Part III are: Music therapy and speech correction, Charles P. Pedry.—Music therapy techniques in the development of speech, Wilhelmina K. Harbert.—Music as an aid in teaching the deaf, Sister Giovanni. The book is indexed.

164

**New Opportunities for Deaf Children**

By: **Irene R. Ewing,** O.B.E., M.Sc., D.C.L., and **Alex W. G. Ewing,** M.A., Ph.D.

1960. 149 p. graphs. Copyrighted by the authors in 1958 and published in 1960 by Charles C Thomas, Publisher, 301-327 E. Lawrence Ave., Springfield, Ill. $4.75.

INTENDED AS A replacement for the authors' earlier book *Opportunity for the Deaf Child,* published in 1945,

the current book, written mainly for parents of deaf children, covers the many aspects of care and management from infancy through the school years. Though slanted toward the British reader in regard to school planning, the general discussions of the psychological aspects of deafness in young children, what can be expected in the way of physical, mental, social, and emotional growth, methods for home training of the child, and new equipment and treatment methods will be of interest to all parents and to professional personnel working with deaf children. Dr. and Mrs. Ewing need no introduction; their research efforts in the field, and especially the screening tests they have devised for use with infants and young children, are well known on both sides of the Atlantic. The advice they offer parents is both constructive and practical. A considerable portion of the book is devoted to fairly detailed case histories of eight children who received early home training; the reports, with one exception, were written by the parents and reveal the p tience and persistence necessary in successful training of deaf children.

165

**Positive Health of Older People**

Edited by: **Betsy Marden Silverman**

1960. 131 p. Paperbound. National Health Council, 1790 Broadway, New York 19, N.Y. $2.25.

BASED ON DISCUSSIONS at the 1960 National Health Forum, an annual event sponsored by the National Health Council as part of its major program activity, this summary offers views expressed by authorities from the fields of sociology, medicine, housing, business, public health, and voluntary organizations concerned with health, welfare, and civic betterment. Current developments and research in the social sciences, social welfare, medicine, and community resources, as they relate to health of the aging, were discussed. Appendixes offer suggestions for action programs in which the individual, commerce and industry, the health professions, voluntary health and welfare agencies, and agencies of government can participate. Staff members of agencies should find the book a useful source of reference in program planning. Indexed.

## New Books To Be Reviewed

The significant new books listed below are to be reviewed critically by well-known authorities in forthcoming issues of *Rehabilitation Literature.*

*Epilepsy and Related Disorders.* By William G. Lennox, M.D. 1960. 2 vols. (1168 p.) illus., figs., tabs. Published by Little, Brown and Co., 34 Beacon St., Boston 6, Mass. $13.50.
*To be reviewed by:* Edward D. Schwade, M.D.

*Special Education of Physically Handicapped Children in Western Europe.* By Wallace W. Taylor, Ph.D., and Isabelle Wagner Taylor, Ph.D. 1960. 497 p. tabs. Published by International Society for Rehabilitation of the Disabled, 701 First Ave., New York 17, N.Y. $3.50.
*To be reviewed by:* John W. Tenny, Ed.D., Professor and General Advisor, Department of Special Education and Vocational Rehabilitation, Wayne State University, Detroit, Mich.

*Welfare in America.* By Vaughn Davis Bornet, Ph.D. 1960. 319 p. illus., tabs. Published by the University of Oklahoma Press, Norman, Okla. $4.95.
*To be reviewed by:* Leonard W. Mayo, S.Sc.D., Executive Director, Association for the Aid of Crippled Children, New York, N.Y.

*Equipment for the Disabled: An Index of Aid and Ideas for the Disabled.* Compiled by Margaret Agerholm, M.A., B.M., B.Ch.Oxon.; Elizabeth M. Hollings, M.A.O.T., and Wanda M. Williams, M.A.O.T. 1960. 4 vols. illus. Looseleaf. Published by National Fund for Research into Poliomyelitis and Other Crippling Diseases, Vincent House, Vincent Square, London, S.W. 1, England. £6 ($21.60) in binder; £4, 10s ($16.20), unbound.
*To be reviewed by:* Muriel E. Zimmerman, O.T.R., B.S., Consultant in Self-Help Devices and Homemaking, Institute of Physical Medicine and Rehabilitation, New York University Medical Center, New York, N.Y.

*The Psychology of Deafness; Techniques of Appraisal for Rehabilitation.* By Edna Simon Levine. 1960. 383 p. illus. Published by Columbia University Press, 2960 Broadway, New York 27, N.Y. $7.75.

*The Psychology of Deafness; Sensory Deprivation, Learning, and Adjustment.* By Helmer R. Myklebust. 1960. xii, 393 p. figs., tabs. Published by Grune & Stratton, Inc., 381 Park Ave., New York 16, N.Y. $7.75.

*Speech Therapy in Cerebral Palsy.* By Merlin J. Mecham, Ph.D., Martin J. Berko, M.A., and Francis Giden Berko, M.A. 1960. 307 p. figs., tabs. *(Am. Lecture ser., publ. no. 400)* Published by Charles C Thomas, 301-327 E. Lawrence Ave., Springfield, Ill. $10.00.

*Social Rehabilitation of the Subnormal.* By Herbert C. Gunzburg, M.A., Ph.D., F.B.Ps.S. 1960. 263 p. illus., figs., charts. Published in England by Bailliére, Tindall & Cox, Ltd., 7 & 8 Henrietta St., London, and distributed in the U.S. by The Williams & Wilkins Co., Baltimore 2, Md. $6.50.

*Orthopaedic Appliances Atlas; Volume 2, Artificial Limbs.* By American Academy of Orthopaedic Surgeons. 1960. 499 p. figs., tabs., charts. Published by J. W. Edwards, Publisher, Ann Arbor, Mich. $15.00.

# Digests of the Month

*Journal articles, chapters of books, research reports, and other current publications have been selected for digest in this section because of their significance and possible interest to readers in the various professional disciplines. Authors' and publishers' addresses are given when available for the convenience of the reader should he desire to obtain the complete article or publication. The editor will be most receptive to suggestions as to new publications warranting this special attention in Digests of the Month.*

166

## What Is a Halfway House? Functions and Types

By: **Brete Huseth**, M.Ed. *(World Federation for Mental Health, 19, Manchester St., London, W.1, England)*

In: *Mental Hygiene.* Jan., 1961. 45:1:116-121.

DECISIVE IN THE DISCHARGE of a patient from the mental hospital are his "level of adjustment," socially and mentally, and the suitability of the environment to which he can return. If the sympathetic and tolerant surroundings "borderline" patients need for support are not available, they often remain in the hospital even though close supervision and hospital facilities are no longer needed. For patients with no family or an unsuitable one, transition to the community from the mental hospital's sheltered environment is often insurmountable. Even when vocational adjustment seems secure, loneliness and homelessness precipitate readmission. For them the usual sheltered workshops and member-employee program are not enough preparation for the outside world. One study has shown work to be almost the last area of the patient's life showing the effects of emotional disturbances.

In the long-term patient both social and vocational problems are more complicated: jobs have long since been filled and family constellations have changed. Often their mates have divorced them or the role of breadwinner or housekeeper and mother has been filled by others. Long-term patients are usually ambivalent about leaving the familiar environment for an unknown pattern of living, which can disturb anyone sick or well. Their social behavior has deteriorated to the minimum level required by the institution.

Coping with social problems interim to hospital and community are: family care programs, ex-patient clubs, day and night hospitals, and halfway houses. A halfway house is a small group residence providing professional supervision and help while allowing more freedom and responsibility than does the mental hospital.

Usually a halfway house has under 50 occupants, but more than one or two, and is residential, helping primarily with social, rather than vocational, skills and handicaps. Some do have ancillary workshops and sewing and laundry rooms. The homelike atmosphere ideally combines support and increasing responsibility for relearning social skills forgotten during long hospitalization. Readmissions from them to hospitals are not excessive; hospital beds are freed for the more acutely ill. Policy changes can be instituted with less effort than under family care programs. Physical facilities can be easily inspected. Less professional time is spent in traveling to see patients and individual attention is given more easily. Feeling is strong that the term *halfway house* should not be used in naming a home—individual names such as "Portals," "Gateways," and "Quarters" are preferred; the four homes in the Vermont program are called "Rehabilitation House," which seems satisfactory.

The several types of halfway houses are distinguished by the kind of resident. A "preventive" halfway house accepts only those whose psychiatric hospitalization might be avoided by an understanding and therapeutic environment. This type is represented by Resthaven in Los Angeles during its early years. It aided people not yet seriously ill but showing signs of emotional disturbance. A halfway house may be for younger patients with good job possibilities who need only a short-term stay. Seven homes of this type have been founded in the United States since 1954 and have been discussed elsewhere. Indiana and Pennsylvania have recently opened such houses; England has several.

A subtype of the "transitional halfway house for ex-patients" is the "quarterway house," which accepts mainly ex-patients going from hospital to another protected environment, their families, or family care homes, or, in England, to Local Authority homes. The "long-term halfway house," developed in Kansas and England, has residents who will never be able to live independently in the community but need a permanent semisheltered home. Advantages are the freeing of hospital beds for the more seriously ill and the provision of a more homelike atmosphere at a feasible cost. A "mixed" halfway house accepts residents in a combination of any or all the above categories. Gould Farm (older group of patients) in Massachusetts, Spring Lake Ranch in Vermont, and Gateways in California all accept ex-patients in need of a transitional facility and those whose hospitalization could be prevented. Gateways has in- and outpatient programs. The Mental After-Care Association of England has a hostel with 6 elderly women as permanent residents and 18

young men as transitional working residents. The grouping is successful; the women help in household affairs and the men are productive and useful, devoting leisure time to community affairs and gardening.

Halfway houses also exist for persons with problems other than psychiatric. The United States and Canada have ones for alcoholics. Illinois and England conduct halfway house programs connected with institutions for mental defectives. There are thoughts of instituting programs for newly released prisoners.

*Mental Hygiene is published quarterly by the National Association for Mental Health, 10 Columbus Circle, New York 19, N.Y.; subscription rates: $6.00 a year (Canadian $6.25; foreign $6.50); single copy $1.50.*

167

**The Nurse—Key Figure in Preventive and Restorative Care**

By: Geraldine Skinner, R.N. *(Director of Nursing Service, Rancho Los Amigos Hospital, Downey, Calif.)*

In: *Hospitals.* Jan. 1, 1961. 35:1:52, 55-56.

REHABILITATION BEGINS the day the patient becomes ill. I am part of an institution in which the entire organization, especially the medical administration and staff, believes the nurse plays a key role in the preventive and restorative aspects of care. She attends all patient-centered conferences and has a definite voice in the total care program of each patient.

At Rancho Los Amigos Hospital, a chronic disease and rehabilitation hospital, every registered or licensed practical nurse and nurse aide is taught how to give bed exercises, range of motion for normal joints, good bed positioning, methods of ambulation, and body mechanics. Every patient with chronic disease is a potential cripple, especially the elderly, and nurses must be ever aware of this. Conditions commonly seen and treated rehabilitatively are: hemiplegia, Parkinson's disease, arthritis, cardiac conditions, cerebrovascular accident, and multiple sclerosis. Patients with chronic emphysema are instructed by the nurse in breathing exercises and good body mechanics.

Let us take as an example in rehabilitative care a patient with a fractured cervical vertebra and spinal cord trauma admitted to a neurosurgical or orthopedic ward with partial or complete quadriplegia. The physician may treat with head traction on an orthopedic bed; he may have exploratory spinal surgery done early to relieve cord or spinal nerve pressure. The nursing staff should realize that at this point the proper preventive and restorative nursing care determines the patient's progress. Breakdown of skin and tissues at pressure points should not be allowed.

There is no magic formula or drug to maintain adequate circulation to involved tissue at pressure points—the only answer is constant turning and relief of pressure. We have "turning teams" to prevent development of reddened areas. The patient assists by watching his skin areas, with a hand mirror, and by shifting his position. The charge nurse or team leader continually evaluates skin conditions and revises turning schedules as needed. While the patient is in a bed or on a frame his position may have to be changed every 30 minutes. Some can tolerate one position for 2 hours—the limit for a bed patient. Some older paraplegics or quadriplegics may rest for prolonged periods prone on stretchers. As a rule, patients whether cared for on a frame or in bed with pillow supports, are turned every 30 to 120 minutes. This also keeps urinary calculi from forming. Thick rubber cushions are placed in a wheel chair if the patients sits in one for prolonged periods. The patient is taught to raise himself and shift position every 5 or 10 minutes.

Decubiti found on patients on admission, if extensive, must be under control or healed before extensive ambulation and muscle building with mat exercises are started. Secondary infections can sap the vitality of patients, retarding rehabilitation and adding to expenses.

In addition to constant turning we have found useful a coating of raw sugar used in the wounds, combined with wet saline dressings, and, when possible, exposure to the sun. Sometimes 18-inch squares of clean deep-pile sheepskins are placed under the patient directly on the skin. These have been autoclaved first to avoid infection. They cushion with little pressure, and the lanolin content is beneficial. Air rings are not used as they cause pressure rings. All dressings are handled as contaminated. We seldom use orthopedic frames.

At least once a day patients should be put through a normal range of motion to prevent periarthritis and maintain normal joint motion—especially in hip, knee, ankle, shoulder, elbow, and wrist. Muscles and joints must be protected by maintaining good body alignment in any position. In a patient with a paralyzed arm and hand, lying unsupported with the thumb in adduction instead of apposition can destroy function of the opponens muscle of the thumb in 10 days or less. The ability to grasp is important. If correct positioning of the arm in abduction and joint exercise is not done conscientiously, adduction of the shoulder soon develops, and the patient cannot raise his arm.

A recurvation of the knee, drop foot, or flexion contractures of the hip may delay rehabilitation as much as a large coccygeal decubitus. If the patient has some muscular ability, he should be taught exercises to do daily. In absence of a physical therapist, the nurse may do this, or it may be a joint project of both. The nurse should not carry range-of-motion exercises beyond the point of pain, although a physical therapist may.

Most hospitals lack enough occupational and physical

therapists to be responsible for joint exercising and similar activities. Professional nurses must teach their nursing team members, practical nurses, and nurse aides to carry these out. Teams work with the physicians and therapists.

Such an intensive rehabilitation program costs at least $30 a day. The average patient remains about 6 months, the patient or county paying around $6,000. If lack of preventive care has delayed rehabilitative treatment, expenses may run to $10,000 or more. What a pity to see time and money being spent to correct conditions good nursing care could have prevented!

*Hospitals is published twice monthly by the American Hospital Association, 840 N. Lake Shore Dr., Chicago 11, Ill.; subscription rates: 1 year $5.00, 3 years $12.00; single copies 30¢, except for two-part August 1, Guide Issue, $2.50.*

168

**Meeting Special Education Needs**

From: The Annual Report of the U.S. Office of Education, 1960. In *1960 Annual Report, U.S. Department of Health, Education, and Welfare,* p. 195-198. 1960. 314 p. U.S. Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. $1.00.

SCHOOL SYSTEMS MUST MAKE many adjustments and add features to their programs to open the doors of opportunities to exceptional children—those with marked physical handicaps, severe mental limitations, or serious social and emotional problems and those with remarkable gifts. Some children and youth can do best in special schools, others in special classes in regular schools. Some need only part-time special education services. At times the school must go to the hospital, institution, or convalescent home or to the child's home.

A comprehensive program includes careful evaluation and placement of children, curriculum adjustments, specially prepared teachers, adapted school housing and equipment, and co-ordination with other related professional services. Few communities have reached this ideal, but the nation's pace is accelerating. Only about 750 public school systems reported special education programs 25 years ago. By 1948 the number had doubled, and by 1958 there were nearly 3,700 programs. According to the 1958 survey, many schools serve the less populated sections and some draw into their programs handicapped or gifted children from 10 or 20 neighboring towns and villages. Enrollments in special schools and classes of public day schools alone increased about 130 percent between 1948 and 1958, over three times the rate that *total* public elementary and secondary school enrollments increased. Local public school systems in 48 states reported special education enrollments as follows.

| *Area of Exceptionality* | *Number of Pupils* |
|---|---|
| Total | 860,814 |
| Blind | 2,742 |
| Partially seeing | 8,266 |
| Deaf | 6,162 |
| Hard of hearing | 13,037 |
| Speech impaired | 474,643 |
| Crippled | 28,355 |
| Special health problems | 21,714 |
| Socially and emotionally maladjusted | 27,447 |
| Gifted | 52,005 |
| Mentally retarded (upper range) | 196,785 |
| Mentally retarded (middle range) | 16,617 |
| Other* | 13,041 |

*"Other" includes the following pupils reported in combined categories of exceptionality: blind and partially seeing, 119; deaf and hard of hearing, 1,993; speech impaired and hard of hearing, 4,493; crippled and special health problems, 4,686; special health problem and socially maladjusted, 22; upper and middle range mentally retarded, 1,403; and multihandicapped, 325.

When public and private residential school enrollments and estimates of private day school enrollments are added, the number of exceptional children receiving special education may reach 1¼ million. Programs still are lagging behind actual needs, not more than 1 child in 4 receiving needed special education. In mental retardation, for example, of an estimated over 1 million needing services, about 243,000 were reported in special classes in day and residential schools. The lag has many causes, *e.g.,* many children live in areas remote from centers with programs, but the principal deterrent to growth is lack of qualified personnel.

The Office of Education has published a series of reports on the competencies desirable for teachers and special educators in various areas of exceptionality. State departments of education are developing and improving standards of teacher certification for specialized areas.

A graduate fellowship program has been developed under Public Law 85-926 for the preparation of college instructors for training teachers of the mentally retarded. Fellowship grants are also available to state educational agencies for preparing leadership personnel to direct and supervise educational programs for the mentally retarded. In fiscal year 1961 grants will be available under the same law to stimulate development of graduate programs in education of the mentally retarded in parts of the nation having no or inadequate opportunity for such.

In 1960, the program's first year, during which all but 7 states participated, grants were made for 177½ fellow-

*(Continued on page 94)*

# *Abstracts of Current Literature*

*This abstracting section, together with other numbered references indexed in this issue, serves as a supplement to the reference book* Rehabilitation Literature 1950-1955, *compiled by Graham and Mullen and published in 1956 by the Blakiston Division of McGraw-Hill Book Company, New York. An author index will be found on the last page of the issue.*

## AMPUTATION—EQUIPMENT

**169. Blashy, Manfred R. M.** *(VA Center, Temple, Tex.)*

Amputation with pylons and the "faulty" gait, by Manfred R. M. Blashy, John Tanzine, and Joseph Oldham. *J. Assn. for Phys. and Mental Rehab.* Nov.-Dec., 1960. 14:6:158-160, 173.

Proper management of lower extremity amputees in the older age group calls for an intermediate period of training on temporary prosthetic devices (pylons). Advantages of pylon training are outlined and arguments advanced against the elimination of pylon ambulation because of "faulty" gait patterns. The problem of the stiff-knee gait has been greatly over-rated; the writers believe it is purely a mechanical difficulty and can be overcome by simple technical means. Modification of the pylon stick by adding weights can solve the problem. Directions for construction of weights and for attaching them to the pylon are included.

## AMPUTATION—SURVEYS

**170. Wolters, Burton J.** *(Wayne State Univ. College of Medicine, Detroit, Mich.)*

Follow-up survey study of a group of elderly above-knee amputees. *Arch. Phys. Med. and Rehab.* Jan., 1961. 42: 1:68-74.

A report of a follow-up study of results achieved in 75 patients over the age of 50 who had above-knee amputations; all received rehabilitation services from the Rehabilitation Institute of Metropolitan Detroit. Because of the many factors that hinder successful rehabilitation in this age group, it was hoped that analysis of experience with these patients might refute some of the suppositions held in regard to prognosis in elderly amputees. Physiologic age, rather than age per se, influences the degree of successful rehabilitation. Generalized disease, multiple diseases, and psychological factors also were prominent features in many patients failing to achieve a satisfactory level of rehabilitation. The author, as a senior medical student and Research Fellow of The National Foundation, received the Bernard M. Baruch Essay Award in 1960 for his report of the study.

## AMPUTATION (CONGENITAL)—EQUIPMENT

**171. MacDonell, James A.** *(50 College Ave., S.E., Grand Rapids 3, Mich.)*

Prosthetic fitting of unusual anomalies of the lower extremity. *Orthopedic & Prosthetic Appliance J.* Dec., 1960. 14:4:56-58.

Opportunity to evaluate more than 500 child amputees during the past 10 years at the Area Child Amputee Center, Grand Rapids, has led to the evolution of a philosophy in the treatment of unusual anomalies. Three case histories illustrate the management of unusual anomalies or complete absence of lower extremities. The author emphasizes the specialized nature of prescription and fitting of prostheses for such children; each child presents an individual problem, making standardization of prescriptions impossible.

## ARTHRITIS—MEDICAL TREATMENT

**172. Henderson, Edward D.** *(Section of Orthopedic Surgery, Mayo Clinic, Rochester, Minn.)*

Rehabilitation of the rheumatoid hand by surgical means, by Edward D. Henderson and Paul R. Lipscomb. *Arch. Phys Med. and Rehab.* Jan., 1961. 42:1:58-62.

Although the place of surgery in the general treatment of rheumatoid arthritis is not formally established, there are many surgical procedures that can be performed on the joints and tendons of the hand to improve function and to reduce or eliminate pain. Drs. Henderson and Lipscomb point out the indications for surgery and the results that can be expected. Most of the operations can be done with the use of local anesthesia; convalescence from primary surgical procedures may require several months, with gradual improvement in function over the entire period. Once a good result has been obtained, improvement appears to be maintained except in patients with a serious flare-up of the arthritis after operation. Surgery is never used merely to improve the appearance of the hand.

## ARTHRITIS—PHYSICAL THERAPY

**173. Pearson, Marjorie**

Osteoarthritis of the hip; a new surgical procedure and the related physiotherapy. *Physiotherapy.* Dec., 1960. 46:12:358-359. Treatment note.

An operation for osteoarthritis of the hip, tentatively named "muscle release" or "soft tissue release," is described briefly. Good results of the operation and the postoperative physical therapy program have been obtained in a majority of the 100 patients operated on to date. The scheme of exercises and the important points to be considered are discussed in some detail. The value of the operation lies in the fact that it is not complicated, is applicable to all age groups, and requires only a 2-week stay in the hospital. Relief from pain is immediate, and, as far as it can be assessed, pain does not return. Poorer results with movement have occurred only where the second hip is also affected and stiff.

## BACKACHE

**174. Bartholomew, Daniel R.** *(Lukens Steel Co., Coatesville, Pa.)*

Rapid rehabilitation of the injured back in an industrial environment, by Daniel R. Bartholomew and Walter G.

Vernon. *Phys. Therapy Rev.* Dec., 1960. 40:12:875-877.
In same issue: Physical therapy for low back pain, Nicholas D. Lorusso. p. 878-880.

A conservative form of therapy used in the treatment of back pain in persons employed in a small steel mill is reported. Observations on 118 patients treated in 1959 are the basis of the study and its findings. The triad of symptoms—pain, spasm, and limited mobility—is discussed. Modalities used were forms of therapy producing tissue heat, followed by passive, then active, motion to achieve total recovery. Electrical muscle stimulation has largely replaced manual massage; application of the method is described. Time lost from work because of back pain has been reduced, as well as wage loss by employees and direct compensation cost to the employer.

Mr. Lorusso *(Ochsner Foundation, New Orleans 21, La.)* stresses the need for accurate diagnosis of low back pain and strict bed rest in the early stages until pain is relieved, followed by graduated exercises and activities. Exercises that have given good results are those designed to reduce the lordotic curve. Regimens of exercises found helpful are described.

## BLIND

*See* 216.

## BLIND—EMPLOYMENT

**175. McCauley, W. Alfred** *(Off. of Vocational Rehabilitation, Region III, Charlottesville, Va.)*

Blind persons in college teaching. *New Outlook for the Blind.* Jan., 1961. 55:1:1-7.

An abstract of a monograph by the same title, published in December, 1960, by the American Foundation for the Blind *(15 W. 16th St., New York 11, N.Y.)*. Results of a questionnaire survey of blind college teachers, college and university administrators, and teacher placement agencies are discussed. Totally blind persons do function successfully as college teachers; implications of the findings for counseling students who show preference for teaching as their life work are considered. Qualifications of the successful blind teacher are enumerated.

**176. Rusalem, Herbert** *(1185 Brooklyn Ave., Brooklyn 3, N.Y.)*

Attitudes toward blind counselors in state rehabilitation agencies. *Personnel and Guidance J.* Jan., 1961. 39:5:367-372.

Because of the interest of blind persons in careers in rehabilitation counseling, a survey of vocational opportunities for blind counselors was conducted in 1959. Agencies serving the blind, the nonblind, and the general caseload were questioned on hiring policies, deterrents to hiring blind counselors, and types of jobs they considered most suitable for such counselors. Findings of the study and their implications for counseling students are examined. Attitudes excluding blind counselors could be changed through several means suggested by Dr. Rusalem.

## BLIND—PSYCHOLOGICAL TESTS

**177. Maxfield, Kathryn E.** *(116 Pinehurst Ave., New York 33, N.Y.)*

The intelligence status of some vocational rehabilitation clients, by Kathryn E. Maxfield and James D. Perry. *New Outlook for the Blind.* Jan., 1961. 55:1:19-20.

A recent study made for the New York Association for the Blind revealed that the mean Wechsler intelligence quotients of 275 vocational rehabilitation clients, divided into three vision groups, were well above mean intelligence quotients for the general population. Comparison of the results with similar earlier studies, cited here, confirmed the belief that blind adults also compare favorably with seeing adults on the Wechsler Verbal Sub-tests.

## BRAIN INJURIES

**178. Barsch, Ray H.** *(Jewish Vocational Service, Milwaukee 2, Wis.)*

Explanations offered by parents and siblings of brain-damaged children. *Exceptional Children.* Jan., 1961. 27: 5:286-291.

A report of research conducted at the Child Development Division, Jewish Vocational Service, Milwaukee (see also *Rehab. Lit.*, Dec. 1960, #908). In counseling with parents of brain-damaged children, it has been found that the need to explain the child's problems to neighbors is a constant source of anxiety to parents. Three check lists were devised to determine types of explanations given by parents and siblings of such children. Six conclusions drawn from analysis of the answers received from parents of 119 brain-damaged children are included. A more detailed investigation of the dynamic factors in the parents regarding their feelings and attitudes toward the term "brain-injured" and the emotional factors involved in the development of feelings about explanations is currently under way.

**179. Sortini, Adam J.** *(300 Longwood Ave., Boston 15, Mass.)*

Rehabilitation of brain-damaged children. *Volta Rev.* Jan., 1961. 63:1:20-23, 42.

Dr. Sortini suggests speech reading and auditory training (with amplification, with an auditory trainer, or with an individual hearing aid) as approaches to problems of the hearing handicapped, brain-damaged child. He also discusses general characteristics of such children and the major problems to be overcome through adaptation of therapy methods to meet the individual child's requirements. Flexibility in approach and the setting of realistic goals are essential. Part I of this paper was listed in *Rehab. Lit.*, Feb., 1961, #101.

## BRAIN INJURIES—PSYCHOLOGICAL TESTS

**180. Avakian, Sonia A.** *(2387 Creston Ave., New York 68, N.Y.)*

The applicability of the Hunt-Minnesota Test for Organic Brain Damage to children between the ages of ten and sixteen. *J. Clin. Psych.* Jan., 1961. 17:1:45-49.

The test, designed for routine clinical use for detecting and giving additional evidence of deterioration in brain-injured persons, has been standardized for adults over 16 years of age. Certain adaptations were made to make the test more applicable for use with children. Results of this investigation, showing a fairly definite differentiation between mean scores of an experimental and a control group of boys between the ages of 10 and 16, support the

belief that the test can be useful in detecting mentally deteriorated children within this age range.

## CAMPING

**181. Frey, Louise A.** *(264 Bay State Rd., Boston, Mass.)*

Open horizons offer handicapped children real camping experiences. *Camping.* Jan., 1961. 33:1:8-9.

A professional social worker shows how handicapped children may be served in the nonspecialized camp through adaptations and modifications in the camp program and physical facilities. The nurse, counselors, and specialists can handle such problems as arise; group work methods familiar to camp personnel are equally appropriate in working with the handicapped. Suggestions on forms of activities, capabilities of staff members, intake policies, and physical considerations of the camp site are given.

*See also* 196.

## CEREBRAL PALSY

*See* 222.

## CEREBRAL PALSY—DIAGNOSIS

**182. Twitchell, Thomas E.** *(171 Harrison Ave., Boston, Mass.)*

The nature of the motor deficit in double athetosis. *Arch. Phys. Med. and Rehab.* Jan., 1961. 42:1:63-67.

Motor deficit in double athetosis results from a defect in maturation or integration of sensorimotor mechanisms, together with corresponding hypertrophy of infantile responses. This paper is concerned with results of an investigation of 30 children with double athetosis, ranging in age from 3 to 16. Pertinent findings from a similar analysis of 200 normal infants, ranging in age from one day to 12 months, are reported. The latter study, currently in progress, is attempting to determine more precisely the neurophysiologic mechanisms of normal motor development. In patients with double athetosis voluntary motor activity is arrested at an early stage; both in these patients and in normal infants the phenomenon of athetosis can be shown to result from disequilibrium between the grasp reflex and the avoiding response.

## CEREBRAL PALSY—MEDICAL TREATMENT

**183. Lesny, I.** *(Neurological Clinic, Charles IV Univ., Prague, Czech.)*

Pituitary implantation in cerebral palsied children, by I. Lesny, V. Vojta, and V. Jelinek. *Cerebral Palsy Bul.* 1960. 2:3:167-169.

Believing that there are few effective medical methods of treating cerebral palsy, other than motor re-education which is, in many cases, insufficient, the authors attempted to accelerate central nervous system development through implantation of bovine pituitary gland beneath the skin of the abdomen. Since 1955, 58 boys and 26 girls, between the age of 18 months and 5 years, have received implantations. Of the total group, 65 had cerebral palsy, the remainder, related conditions. Improvement was noted in 22.5% of the children, with mild improvement in an additional 53.5%. Experimental research to determine hormonal activity in bovine pituitary glands is described.

## CEREBRAL PALSY—PSYCHOLOGICAL TESTS

**184. Wedell, K.** *(Child Guidance Clinic, Bristol, Eng.)*

Variations in perceptual ability among types of cerebral palsy. *Cerebral Palsy Bul.* 1960. 2:3:149-157.

In same issue: Perception and eye movements; some speculations on disorders in cerebral palsy, M. L. Johnson Abercrombie. p. 142-148.

A report of research supported in part by a grant from the National Spastics Society. Low perceptual ability within a group of cerebral palsied children appeared to be associated with spasticity rather than with athetosis and with bilateral and left-sided, rather than right-sided, spasticity. Motor and visual handicaps seem to have a contributory rather than a determining effect in low perceptual ability. Results indicate that type of cerebral palsy is the main determining factor in perceptual impairment. A possible relationship between degree of prematurity and perceptual impairment was indicated. Neurological implications of the findings are discussed.

Dr. Abercrombie *(Med. Research Unit, Guy's Hosp., London)* calls attention of psychologists to the possible relevance of disordered eye movements to disordered perception in cerebral palsy. If a casual relationship can be established, and if means could be found to treat oculomotor disturbances in early life, he believes it might be possible to prevent development of some of the disorders of perception.

## CEREBRAL PALSY—RECREATION

**185. United Cerebral Palsy Associations**

*More than fun; a handbook of recreational programming for children and adults with cerebral palsy,* by Sylvia B. O'Brien. New York, UCP (1960?). 38 p. illus.

This guide, intended for agency personnel and professionals in the fields of recreation, physical education, and group work, reviews community responsibility for program planning, actual steps in identifying those to be served, organization of the program to meet needs of participants, adapting activities for the handicapped, and forms of recreation to be included. Suggestions are offered for securing parents' co-operation, on equipping and financing the program, and on leadership responsibilities of professional and volunteer workers. Additional sources of information on the handicapped and on recreational literature are included.

Available from United Cerebral Palsy Associations, 321 W. 44th St., New York 36, N.Y., at 20¢ a copy (less in quantity orders of 100 or more copies).

## CEREBRAL PALSY—SPECIAL EDUCATION

**186. United Cerebral Palsy Associations of New York State**

*Aphonic communication for those with cerebral palsy; guide for the development and use of a conversation board; report of the Rochester-Leroy Area Study Group,* co-editors, Herman R. Goldberg and Joseph Fenton. . . . New York, UCP Assns. of N.Y. State (1960). 41 p. illus.

Severe speech defects and inco-ordination of hand movements are the cause of many cerebral palsied children's inability to communicate through spoken or written language. The educational device described here, a con-

versation board experimentally tested in classrooms of a public school, a day clinic, and a residential clinic, uses a selected Basic English word list. Five graded boards, developed to meet the needs from preprimer level to adult level, are discussed and illustrated. Directions for construction of the boards and for their use in teaching language and number concepts are included. The Dolch list of basic words is given in the appendix. Five case studies illustrate usefulness of the device as a teaching aid and a motivating factor in the children's efforts to communicate. The adult board is one presently used by F. Roe Hall, who shared his experiences in developing and using the basic idea with the study group. In 1948 he wrote an article that appeared in *Hygeia* (26:348-394), describing the use of a simple word board at the Illinois Children's Hospital School, Chicago.

Copies of the booklet are available from United Cerebral Palsy Associations of New York State, 220 W. 42nd St., New York 36, N.Y., at 50¢ each.

*See also* 221.

## CHILD GUIDANCE

*See* 160.

## CHRONIC DISEASE

*See* 159.

## CHRONIC DISEASE—MICHIGAN

**187. Rae, James W., Jr.** *(Dept. of Phys. Med. and Rehab., Univ. of Michigan Med. School, 1313 E. Ann St., Ann Arbor, Mich.)*

A comprehensive evaluation of the county hospital patient, by James W. Rae, Jr., Edwin M. Smith, and Alma J. Murphy. *Arch. Phys. Med. and Rehab.* Jan., 1961. 42:1:53-57.

A report of one phase of a study and demonstration project being conducted by the University of Michigan's Department of Physical Medicine and Rehabilitation and the Division of Gerontology. Purpose of the study is to evaluate current medical status, functional ability, psychosocial level, and vocational potential of county hospital patients; the demonstration project will attempt to help patients, through rehabilitation technics, to reach their maximum level of physical, social, and vocational independence. This article describes methods used in the multiple-discipline approach to evaluation of patients' rehabilitation potential. The entire April, 1960, issue of *Geriatrics* was devoted to reports of studies from the research-demonstration project (see *Rehab. Lit.*, June, 1960, #393).

## CHRONIC DISEASE—PROGRAMS

**188. American Public Health Association**

*Chronic disease and rehabilitation; a program guide for state and local health agencies,* prepared by the Program Area Committee on Chronic Disease and Rehabilitation. . . . New York, The Assn., 1960. 116 p. Paperbound.

Various approaches on which health departments may base their efforts to meet the problems of chronic disease and disability within the community are suggested, showing how practical program components can be adapted to meet local conditions. The guide should be an aid to health departments reviewing the adequacy of their current programs in regard to prevention, early detection, treatment, and rehabilitation. Many of the processes of health promotion, primary and secondary prevention of disease, early case findings, diagnosis, follow-up, treatment, and rehabilitation have been evolved and used successfully in maternal and child health services and indicate what might be done for other age groups of the chronically ill.

Available from American Public Health Association, 1790 Broadway, New York 19, N.Y. at $2.50 a copy.

## CONFERENCE OF REHABILITATION CENTERS AND FACILITIES—PROCEEDINGS

**189. Conference of Rehabilitation Centers and Facilities**

*Selected papers, Eighth Annual Workshop . . . December 4-8, 1959, New York. . . .* Evanston, The Conference, 1960. 20 p.

With the theme "Preparation for living, a goal of rehabilitation," the program of the 1959 Conference workshop was mainly directed toward two aspects of the rehabilitation program—psychosocial and vocational adjustment. Included with the papers made available for publication are two heretofore unpublished papers from the 1958 workshop.

Contents: The psychological determinants of social adjustment in the disabled, Morton A. Seidenfeld.—Mental hygiene concepts in rehabilitation; theoretical aspects, Harold Chenven.—Mental hygiene concepts in rehabilitation center; clinical aspects, Lester A. Gelb.—Interpretation of prevocational efforts to the client, Karl L. Ireland.—The employment handicap, Robert Walker.—Readiness for employment, Ann Altman.—Current programs and developments in rehabilitation in the federal government, Henry Redkey.—The importance of community planning in the development of rehabilitation, Leonard W. Mayo.—A reporting system for rehabilitation centers and facilities, Basil J. F. Mott.—"What is the role of a national organization in the field of rehabilitation?" C. F. McNeil.—Operational research and rehabilitation, Basil J. F. Mott.

Included in the report are lists of institutional and associate members of the Conference with their addresses.

Available from Charles E. Caniff, Exec. Director, Conference of Rehabilitation Centers and Facilities, 828 Davis St., Evanston, Ill., at $1.00 a copy.

## CONGENITAL DEFECT—ETIOLOGY

**190. Colorado. University Medical Center. Human Chromosomes Study Group**

A proposed standard of nomenclature of human mitotic chromosomes. *Cerebral Palsy Bul.* 1960. (Suppl. to 2:3.) 9 p. figs., tabs.

A study group composed of scientists in the field of human cytology from European countries, the United States, and Japan met at the University of Denver to formulate a common system of nomenclature. Confusion in the literature has resulted because of the rapid growth of knowledge of human chromosomes and the various systems by which they are named. This supplement of *Cerebral Palsy Bulletin* explains the classification system and how it should be used. Co-ordination of research was

also discussed at the study group meeting, sponsored by the American Cancer Society.

Available from National Spastics Society, 28 Fitzroy Sq., London, W. 1, England, at 5s or $1.00 a copy, postpaid.

*See also* 234; 235.

## CRIME

**191. Hinkle, Van R.** *(Washington State Dept. of Institutions, Olympia, Wash.)*

Criminal responsibility of the mentally retarded. *Am. J. Mental Deficiency.* Jan., 1961. 65:4:434-439.

Laws of Great Britain and the United States that operate to the disadvantage of the adult with mental deficiency are discussed. Standard legal tests to establish responsibility for acts that transgress the law are not in harmony with modern medical science. The experience of the state of Maryland with its Defective Delinquent Law should be studied by every state concerned with the problem. Public interest in protecting society from mentally deficient persons who have clearly shown themselves to be an actual danger is best served by providing treatment, hospitalization, or confinement. Punishment under traditional criminal process does not provide adequate safeguards for the mentally deficient.

## DEAF

**192. Rehab. Record.** Nov.-Dec., 1960. 1:6.

Special section: Deafness; new approaches.

Contents: Problems and prognosis, Boyce R. Williams and Elizabeth A. Chase, p. 17-21.—Occupations of the deaf, Stanley K. Bigman, p. 23-26.—Deaf-blind persons; an epic study, Herbert Rusalem, p. 26-30.—Captioned film program underway, p. 30.—Training people to aid the deaf, p. 31-32.—Psychological assessment of the deaf, Edna Simon Levine, p. 33-34.—Counseling center for the deaf, Howard L. Roy, p. 35-36.

Articles in this issue of *Rehabilitation Record* that are concerned with rehabilitation efforts in behalf of deaf persons report on findings of research projects supported by the Office of Vocational Rehabilitation. A number of the reports have been listed and annotated in earlier issues of *Rehab. Lit.* (see Apr., 1959, #307; July, 1959, #532; Nov., 1959, #820; Feb., 1960, #102; Aug., 1960, #585; and Dec., 1960, #924).

*See also* 158; 164.

## DEAF—BIOGRAPHY

**193. Petkovsek, Marian** *(2023 W. Ogden Ave., Chicago 12, Ill.)*

The eyes have it. *Hearing News.* Jan., 1961. 29:1:5-9.

In this talk given at the annual meeting of the North Dakota Society for Crippled Children and Adults in September, 1960, the editor of the National Society for Crippled Children and Adults' *Easter Seal Bulletin* tells of her reactions to complete deafness. Mumps, accompanied by sleeping sickness, caused a nerve loss that cannot be corrected surgically or alleviated by a hearing aid. In spite of the fact that deafness struck as she was completing high school, Miss Petkovsek attended the State University of Iowa and majored in journalism. She gives some sound advice on general attitudes toward the deaf, how to cope psychologically with deafness, and how to live as normal a life as possible.

## DEAF—PSYCHOLOGICAL TESTS

**194. Rosenstein, Joseph** *(Lexington School for the Deaf, 904 Lexington Ave., New York 21, N.Y.)*

Perception, cognition and language in deaf children. *Exceptional Children.* Jan., 1961. 27:5:276-284.

In this critical analysis and review of the literature, based in part on the author's doctoral dissertation, Dr. Rosenstein notes the lack of agreement among investigators dealing with perceptual and conceptual abilities in the deaf. Pertinent definitions and concepts are examined briefly before analysis of the literature is attempted. Studies concerned with intelligence in deaf children, perceptual and conceptual organization, sorting behavior, visual memory, rigidity and perseveration, and abstract reasoning are discussed in some detail. Opinions and findings on the relation between language and thought, taken from the fields of psycholinguistics and psychology, suggest a close involvement. Conditions may exist, however, in which thought is carried on without verbal or linguistic behavior. A recent study by the author (see *Rehab. Lit.*, Aug., 1960, #584) found no differences in conceptual performance between groups of deaf and hearing children; however, linguistic factors were within the language experience of the sample of deaf children. Findings have implications for the educational methods used in developing ability in deaf children to conceptualize. 59 references.

## DENTAL SERVICE

**195. Lyons, Don Chalmers** *(W. A. Foote Hosp., Jackson, Mich.)*

The dental problems of handicapped children. *Children.* Jan.-Feb., 1961. 8:1:14-16.

Any complete rehabilitation program for handicapped children should include comprehensive dental care; when such care is given, the percentage of dental disturbances found in handicapped children is similar to that evident in normal average children. Because of the costs of effective dental care programs and the shortage of trained personnel, this aspect of the child's treatment is often neglected. Special problems in treating the physically handicapped child or the child who is homebound are discussed.

## DIABETES

**196. Weil, William B., Jr.** *(Babies and Children's Hosp., University Hospitals of Cleveland, University Circle, Cleveland 6, Ohio)*

Behavior, diet and glycosuria of diabetic children in a summer camp, by William B. Weil, Jr., and Marvin B. Sussman. *Pediatrics.* Jan., 1961. 27:1:118-127.

A report of an experimental study to determine the effect of two different dietary programs on regulation of the disease and on the children's behavior. Glycosuria, hypoglycemia, self-regulated and prescribed diets, emotional adjustment, and measures of group structure were recorded and correlated to determine the relationship between psychologic-sociologic factors and metabolic changes

in the diabetic state. Findings are of interest in the light of previous demonstrations of a relationship between emotional disturbances and overeating.

## EXERCISE

**197. Ford, Amasa B.** *(2073 Abington Rd., Cleveland 6, Ohio)*

The energy cost of work. *Phys. Therapy Rev.* Dec., 1960. 40:12:859-862.

Studies of the energy expenditure of men with and without heart disease, working in factories and steel mills, of amputees and paraplegics, and of elderly and chronically ill patients revealed a wide variance in exercise tolerance. Dr. Ford suggests that, since activities of daily living and physical therapy require more energy for the disabled to perform and his reserves of energy tend to be smaller, it is necessary to determine each patient's capacities and goals on an individual basis. Several means for determining energy expenditure are discussed.

## HARD OF HEARING

*See* 179.

## HEART DISEASE—EMPLOYMENT

**198. American Heart Association. Rehabilitation Committee**

*National Conference on Work Evaluation Units: proceedings, May, 1960, Arden House, Harriman, New York.* New York, The Assn., 1960. 73 p. tabs. Mimeo. Paperbound.

Proceedings of the Second National Conference on Work Evaluation Units contain individual papers, reports of workshop and panel discussions, their resolutions and recommendations, and a report of the ad hoc committee on functional and therapeutic classification. The First Conference, held in 1954, was mainly exploratory; in the nearly 6 years that have elapsed between conferences, continued experience with the units has brought better understanding of their role in the community and the relative value of administrative and organizational operative procedures. Evaluation of the units' accomplishments and their future development was also attempted. Research potentials of work evaluation units and recommended practices of physicians, social workers, vocational counselors, psychologists, and psychiatrists as members of the professional staffs of units were explored. Forms used by the American Heart Association for collecting statistical data on work evaluation unit experience are included in the appendix.

Distributed by the Rehabilitation Committee, American Heart Association, 44 E. 23rd St., New York 10, N. Y.

## HEMIPLEGIA

**199. Rosenthal, Aaron M.** *(1166 E. Phil-Ellena St., Philadelphia 19, Pa.)*

Rehabilitation of the hemiplegic patient. *Pa. Med. J.* Jan., 1961. 64:1:56-59.

In restating the major principles of rehabilitation in programs for hemiplegic patients, Dr. Rosenthal offers a detailed treatment program, with suggestions for ways of evaluating prognosis and progress and prescribing the various phases of the treatment program. Of major importance are the setting of realistic goals, co-ordination of efforts of all personnel involved in treatment, and careful follow-up of discharged patients' progress.

## HEMIPLEGIA—DIAGNOSIS

**200. Simon, David J.** *(1821 DeLoz Ave., Los Angeles, Calif.)*

Observations based on monitoring the tonic neck reflex and associated reactions in the hemiplegic patient by multichannel electromyography. *J. Am. Osteopathic Assn.* Jan., 1961. 60:5:355-358.

The balance of facilitation and inhibition of reflex postural and movement patterns may be critically disturbed in the hemiplegic patient. Since the tonic neck reflex changes the distribution of muscle tone throughout the body in response to proprioceptive stimuli originating in the neck muscles and joints, careful individual observation and repeated trials with the patient in different positions is necessary if therapeutic advantage is to be taken of the tonic neck reflex and associated reactions during retraining. A method for testing and observations made during the investigation are discussed. Subjects of the study were nine ambulatory hemiplegic patients.

## HOMEBOUND—PROGRAMS

**201. Littauer, David** *(216 S. Kingshighway Blvd., St. Louis 8, Mo.)*

Home care; summary of a comprehensive study, by David Littauer, I. Jerome Flance, and Albert F. Wessen. *Hospitals.* Jan. 16, 1961. 35:2:41-43.

Presents the background and results of a comprehensive study of home care programs issued in monograph form by the American Hospital Association. A joint report of the Medical Care Research Center of Jewish Hospital, St. Louis, and the Social Science Institute of Washington University, it considers the general structure of home care programs, describes organization and operation of Jewish Hospital's program, and compares it with similar ones operated by other agencies. The program administered and sponsored by the general hospital is, in authors' opinion, best for the patient, for the hospital and health professions, for participating service organizations, and for the community itself.

The full report is available from the American Hospital Association, 840 N. Lake Shore Dr., Chicago 11, Ill. at $2.75 a copy.

## HYDROCEPHALUS

**202. Laurence, K. M.** *(Llandough Hosp., Penarth, Glamorgan, Wales, Gt. Britain)*

Hydrocephalus and disability. *Cerebral Palsy Bul.* 1960. 2:3:170-179.

Prognosis in hydrocephalus is now much more optimistic; an investigation made by the author in 1958 showed that many children with the condition do survive and without surgical intervention (see *Rehab. Lit.*, Feb., 1959, #124). It is believed that the physical and mental handicaps in those who survive are not so much a result of actual thinning of the cortex as of associated malformations and secondary changes. An explanation of the cerebrospinal fluid circulation and the pathology of hydrocephalus and associated conditions is given.

## LARYNGECTOMY

**203. Gilmore, Stuart I.** *(Bill Wilkerson Hearing and Speech Center, 19th Ave. S. at Edgehill, Nashville, Tenn.)*

Rehabilitation after laryngectomy. *Am. J. Nursing.* Jan., 1961. 61:1:87-89.

Rehabilitation for the laryngectomy patient should include, in addition to speech retraining, social and vocational restoration. Economic problems and interpersonal relations with family, friends, and the general public compound the patient's difficulties. Preoperative instruction and counseling, participation in group programs, and activity in public education programs can aid recovery. This article was adapted from a speech delivered at a Cancer Nursing Institute, sponsored by the American Cancer Society, at Columbia, S.C., in March, 1960.

## MENTAL DEFECTIVES

*See* 191; 222.

## MENTAL DEFECTIVES—ETIOLOGY

**204. Henderson, Robert A.** *(Bureau of Special Education, California State Dept. of Education, Sacramento 14, Calif.)*

The attack on phenylketonuria; a pilot study, by Robert A. Henderson and Willard R. Centerwall. *Exceptional Children.* Jan., 1961. 27:5:260-263.

A report of a screening survey of children enrolled in special classes in San Diego County, Calif., to determine the presence of phenylpyruvic acid in the urine, the confirmatory tests for phenylketonuria, a recessive, familial disease. A brief historical sketch of the discovery of the disease as an etiological condition in mental retardation is given, as well as a description of the disease and its hereditary aspects. Data from the findings are included. A U.S. Public Health Service research grant is being sought to support a state-wide demonstration study of the approximately 40,000 mentally retarded children in public and private schools of California.

## MENTAL DEFECTIVES—PROGRAMS

**205. Wortis, Joseph** *(152 Hicks St., Brooklyn 2, N.Y.)*

International communication and co-operation in the field of mental retardation. *Am. J. Mental Deficiency.* Jan., 1961. 65:4:426-433.

A review of activities in the field of mental retardation in countries all over the world, the services available, and the organization of parent groups. Dr. Wortis makes a number of specific recommendations that, implemented, might promote international co-operation and communication on important research undertakings. The paper was presented before the general assembly of the American Association on Mental Deficiency's annual meeting in 1960 in connection with World Mental Health Year.

## MENTAL DEFECTIVES—PSYCHOLOGICAL TESTS

**206. Dunn, Lloyd M.** *(George Peabody Coll. for Teachers, Nashville, Tenn.)*

Peabody Picture Vocabulary Test performance of trainable mentally retarded children, by Lloyd M. Dunn and John V. Hottel. *Am. J. Mental Deficiency.* Jan., 1961. 65:4:448-452.

Validity and reliability of the PPVT as a useful test for trainable mentally retarded children was investigated; subjects were 220 children enrolled in special day classes of Tennessee. Scores of both forms of the test were obtained by teachers. The PPVT was found to exhibit high alternate form reliability, but its predictive validity was less than that for the Revised Stanford-Binet Intelligence Test in terms of language arts achievement in reading and writing. An interesting finding of the study was the fact that only 8% of the 220 children had achieved a sight vocabulary of 16 words or better in reading; only 12% could print or write at least 3 to 5 words from memory. Grave doubt is cast on giving major attention to teaching reading and writing in classes for trainable children. For other articles discussing the PPVT, see *Rehab. Lit.,* Oct., 1960, #749, and Dec., 1959, #903.

**207. Griffith, Belver C.** *(E. R. Johnstone Training and Research Center, Bordentown, N.J.)*

The use of verbal mediators in concept formation by retarded subjects at different intelligence levels. *Child Development.* Dec., 1960. 31:4:633-641.

Earlier studies found retarded subjects, especially those with IQ's below 65, had little success in reporting a similarity among 3 words when they were unable to define at least 2 of the words in terms of an acceptable abstraction. Less extreme results were obtained from those with IQ above 65. The present experiment increased the stimulus sets from 3 words to 6, in an effort to determine whether performance in reporting similarities depended upon the retarded person's ability to define some constant proportion of the stimulus words in terms of a possible abstraction. Those in the lower IQ range were found to have little success unless they could define approximately two-thirds of the words in each group.

**208. Miller, D. R.** *(Pacific State Hospital, Pomona, Calif.)*

A note on differential utility of WAIS Verbal and Performance IQ's, by D. R. Miller, G. M. Fisher, and H. F. Dingman. *Am. J. Mental Deficiency.* Jan., 1961. 65:4:482-485.

A report on one phase of the Population Movement Study, a long-term research project at Pacific State Hospital partially supported by a grant from the National Institute of Mental Health. (For earlier reports of the study, see *Rehab. Lit.,* Nov., 1959, #842, and Sept., 1960, #662.) The Wechsler Adult Intelligence Scale was administered to 200 patients at the Hospital (101 females and 99 males); Verbal IQ on the Scale is believed to be a significant predictor of the release rate for male patients at a state institution for the mentally retarded. Neither the Verbal or Performance IQ provides for differential prediction for females.

## MENTAL DEFECTIVES—SPECIAL EDUCATION

**209. Bardon, Jack I.** *(Graduate School of Education, Rutgers Univ., New Brunswick, N.J.)*

An approach to the educational classification of mentally retarded children, by Jack I. Bardon and Stanley I. Alprin. *Exceptional Children.* Jan., 1961. 27:5:235-238.

The nature of the educational classification of mentally retarded children and ways in which the procedure can be improved to the satisfaction of the educator, classification specialist, and the child are considered. The authors describe, as a case in point, the laws and regulations governing classification in New Jersey. Lack of time and adequate staff precludes carrying out the ideal classification scheme described; suggestions are made, however, for improving the services of the itinerant examiner, the overworked school psychologist, and the clinic services available to the school. One point emphasized is the major responsibility the school must assume for establishing evaluation procedures.

## MENTAL DISEASE—EMPLOYMENT

**210. Margolin, Reuben J.** *(VA Hosp., Brockton, Mass.)*

A survey of employer reactions to known former mental patients working in their firms. *Mental Hygiene.* Jan., 1961. 45:1:110-115.

A report of a survey of attitudes of employers who had, with full knowledge, hired former mental hospital patients, all of whom had worked as member employees of the VA Hospital at Brockton (for a description of the Member Employee Program, see *Rehab. Lit.*, Jan., 1959, #43). Strengths and weaknesses of employees in job situations were revealed in comments of employers. There is still a great need for improvement in rehabilitation programs that will meet the demands of industry, Dr. Margolin believes.

**211. Wolfe, Harvey E.** *(Longview State Hosp., Box 36, Cincinnati 16, Ohio)*

The attitude of small industrial employers toward hiring of former state mental hospital patients. *J. Clin. Psych.* Jan., 1961. 17:1:90-92.

Officials of 934 manufacturing firms employing from 1 to 99 persons were interviewed to determine their attitudes toward hiring former state mental hospital patients. Evaluation of the data suggests that the majority favored hiring of such persons; comparison of data from a previous study (see *Rehab. Lit.*, Sept., 1960, #668) indicates no substantial differences between hiring attitudes of smaller and larger industrial firms in the same Midwestern city.

## MENTAL DISEASE—PROGRAMS

**212. Wechsler, Henry** *(30 Barry Rd., Worcester, Mass.)*

Transitional residences for former mental patients; a survey of halfway houses and related rehabilitation facilities. *Mental Hygiene.* Jan., 1961. 45:1:65-76.

In same issue: What is a halfway house? Functions and types, Brete Huseth. p. 116-121.

The paper by Dr. Wechsler is based on a survey conducted as part of the Massachusetts Mental Health Center (Boston) Rehabilitation Project. Two types of transitional residences for discharged mental patients—the halfway house and the work camp—are described; their functions, physical facilities, ancillary services, and characteristics of residents and their staffs and administration are compared. Of the nine transitional residences in existence in the U. S., most have been established in the past 5 years, evidence of the new trend in community programs. (See this issue of *Rehab. Lit.* #166, for a digest of the article by Miss Huseth.)

## MENTAL DISEASE—SPECIAL EDUCATION

**213. Douglas, Katherine B.** *(Div. of Child Psychiatry, Univ. of Minnesota School of Medicine, Minneapolis 14, Minn.)*

The teacher's role in a children's psychiatric hospital unit. *Exceptional Children.* Jan., 1961. 27:5:246-251.

Teaching in the psychiatric ward schoolroom calls for recognition of the necessity for working within the limitations, needs, and the child's aberrant behavior. Case histories are used to illustrate means of establishing rapport, general and specific methods of instruction, the importance of the teacher's attitudes, use of discipline, structuring the physical setting, and the teacher's role in the total therapeutic program.

## MENTAL HYGIENE

**214. Seidenfeld, Morton A.** *(The National Foundation, 800 Second Ave., New York 17, N.Y.)*

Emotional aspects of disability (evolving techniques). *Public Aid in Illinois.* Dec., 1960. 27:12:12-16.

In same issue: Mental and emotional aspects of rehabilitation, Francis J. Gerty. p. 6-8.

Written to aid the public assistance worker in his understanding of the handicapped person's reactions to disability, of the variables that influence extent and depth of individual reactions, and how professional rehabilitation workers can help the disabled in their acceptance of the limitations that must be overcome on a mature emotional basis. This paper and Dr. Gerty's were presented at the National Rehabilitation Association Conference in Chicago, May, 1959.

Dr. Gerty *(8 S. Michigan Blvd., Chicago 3)* notes that rehabilitation encompasses both mental and physical aspects, even in those whose disability is purely physical. Prompt treatment, within the community, can reduce the rehabilitation problems of the person with acute mental or emotional disturbances. Psychiatry has a definite contribution to make to rehabilitation programs; one of its main aims in improving medical treatment and rehabilitation is to make all persons involved in treatment aware of the importance of interpersonal relationships and emotional aspects.

## MONGOLISM—PARENT EDUCATION

**215. Yates, Mary L.** *(Gales Child Health Center, 65 Massachusetts Ave., N.W., Washington 9, D.C.)*

Small, short-term group meetings with parents of children with mongolism, by Mary L. Yates and Ruth Lederer. *Am. J. Mental Deficiency.* Jan., 1961. 65:4:467-472.

Services for the Retarded Child, a special program of the Bureau of Maternal and Child Health of the Government of the District of Columbia Department of Health, offers diagnostic, treatment, and follow-up services. Short-term, small, undirected-group sessions, spread over a 3-month period, with both parents attending, appeared to be quite helpful and useful. The technics worked best with those parents able to put their feelings into words and seemed to help them in their adjustment during the period following interpretation of the diagnosis. Role of the

sponsors (staff psychologist and social worker) in group sessions is discussed.

## MULTIPLE HANDICAPS

**216. Moor, Pauline M.** *(Am. Found. for the Blind, 15 W. 16th St., New York 11, N.Y.)*

Blind children with developmental problems. *Children.* Jan.-Feb., 1961. 8:1:9-13.

Many children, blind since infancy, are presenting grave problems to parents and professional persons interested in their welfare. Their additional handicaps appear to be more of a behavioral nature than physical; appraisal of the child's level of development is difficult since a variety of factors may be responsible for retardation. General observations of such children reveal some errors in management; means of strengthening programs of service to blind children and their parents are suggested.

## MULTIPLE SCLEROSIS—STATISTICS

**217. Acheson, E. D.** *(Div. of Geographic Epidemiology, Veterans Admin., Washington 25, D.C.)*

The distribution of multiple sclerosis in U.S. veterans by birthplace, by E. D. Acheson and C. A. Bachrach. *Am. J. Hygiene.* July, 1960. 72:1:88-99.

Explains methods of compiling epidemiologic studies from veterans' case records and analyzes data on a sample of 1,782 U.S. veterans with multiple sclerosis. When the cases were distributed according to birthplace, it was found that multiple sclerosis became progressively more frequent from South to North within the U.S. at all longitudes; progression held true for both whites and Negroes, considered separately. Findings support those of earlier studies stating the greater prevalence of the condition in the North than in the South of this country.

## MUSCLES—TESTS

**218. Bauwens, Philippe** *(Dept. of Physical Medicine, St. Thomas' Hosp., London, Eng.)*

Electrodiagnosis revisited: Tenth John Stanley Coulter Memorial Lecture. *Arch. Phys. Med. and Rehab.* Jan., 1961. 42:1:6-18.

In same issue: Standard routine and procedure to establish uniformity in clinical electromyography, Karl H. Haase. p. 33-42.—Electromyographic evaluation of the "cross exercise" effect, Nicholas Panin (and others). p. 47-52.

Electrodiagnosis, only one of the many methods used in physical medicine, is regarded by the writer as merely a highly specialized form of investigation into muscle function. The complete electrodiagnostic examination consists of three related parts—study of muscle behavior on stimulation, on electromyographic exploration, and on electromyographic exploration during stimulation. The importance of regarding the muscle to be examined as an integrated aggregate of muscle fibers organized into motor units, rather than as an anatomic entity, is stressed. An important part of electromyography at rest, on volition, and on stimulation is the search for muscle fibers that deviate from the normal and provide clues of diagnostic value.

Dr. Haase *(VA Center, Los Angeles 25, Calif.)* shows the need for standardization of routines and equipment in electromyography if electrodiagnosis is to be of value, especially from the standpoint of medicolegal application of the technic. Standardized technics used at the Wadsworth General Medical and Surgical Hospital of the Los Angeles VA Center are described; the routine has evolved from 8 years' experience, including yearly evaluations of some 500 to 600 electromyograms. The examination should be carried out only by a trained physician. Criteria for interpreting results are discussed, as well as information that should be included in the written report.

Dr. Panin *(VA Hosp., East Orange, N.J.)* and his coworkers report experimental electromyographic studies of muscles in upper and lower extremities to determine the effect of exercise of one muscle upon nonexercised muscles. Subjects of the study were normal healthy young men. Greatest electromyographic activity was found in the exercised muscle, with potentials of low amplitude and low frequency found in all nonexercised muscles studied. Potentials were of insufficient magnitude to constitute exercise effort. Methods of the study are described.

## MUSCULAR DYSTROPHY

**219. Dubowitz, Victor** *(Institute of Neurology, Queen Square, London, W. 1, Eng.)*

The myopathies. *Physiotherapy.* Dec., 1960. 46:12: 341-346.

In same issue: Demonstration, Robert J. S. Reynolds. p. 347-349 (Congress Lecture and Demonstration)

A broad survey of inherited or acquired diseases of muscle, some of the symptoms of the various forms, research findings of histochemical studies, and the course of the disease in muscular dystrophy. The demonstration by Mr. Reynolds, Superintendent Physiotherapist at Queen Mary's Hospital for Children *(Carshalton, Surrey, Eng.)* illustrated clinical features of the Duchenne or pseudohypertrophic form of muscular dystrophy and of amyotonia congenita. Care and management of children with such conditions require the services of those in the fields of medicine, physical therapy, nursing, social welfare, and education. Both articles are illustrated.

## MUSCULAR DYSTROPHY—MENTAL HYGIENE

**220. Sherwin, Albert C.** *(525 E. 68th St., New York 21, N.Y.)*

Reactions observed in boys of various ages (ten to fourteen) to a crippling, progressive, and fatal illness (muscular dystrophy), by Albert C. Sherwin and Robert S. McCully. *J. Chronic Diseases.* Jan., 1961. 13:1:59-68.

A report of a study of the psychologic effects of muscular dystrophy in young boys under treatment at the day care program of the Payne Whitney Psychiatric Clinic over a 3-year period. Reactions to the disease and findings of the study are reviewed. There was a relative absence of serious emotional illness, overt anxiety or depression, and predominant modes of behavior and attitudes. "Seesaw" responses, relatively retarded development of conscious controls over behavior, especially in interpersonal and group activities, and excessive reliance on fantasy life as a source of satisfaction were observed. Motility appeared so important to these boys psychologically that progressive disability did not seem to diminish interest in these areas. Treatment implications of the findings are considered.

## MUSIC THERAPY

*See* 163.

## NEUROLOGY

*See* 158.

## NURSERY SCHOOLS—CALIFORNIA

221. **Headley, Lee** *(United Cerebral Palsy Assn. of San Mateo County, Calif.)*

A nursery school for cerebral palsied children, by Lee Headley and Hazel Leler. *Children.* Jan.-Feb., 1961. 8:1:17-21.

The program of the San Mateo Cerebral Palsy Nursery School, established in 1956 under joint sponsorship of the College of San Mateo and United Cerebral Palsy Association of San Mateo County, is described. Parent education classes, group psychotherapy, and inclusion of normal siblings in nursery school classes are all services that have helped families to accept and deal with their own feelings and the needs of the handicapped children. Programs of a similar nature could be used advantageously in working with children with other types of handicaps.

## NURSING

*See* 162; 222; 233.

## NUTRITION

222. **Pitts, John L.** *(Bur. of Maternal and Child Health, Baltimore City Dept. of Health, Municipal Bldg., Baltimore 2, Md.)*

An approach to meeting the nutritional needs among tube-fed severely retarded spastic children, by John L. Pitts, Benjamin Daniel White, and Mattie L. Coates. *Am. J. Mental Deficiency.* Jan., 1961. 65:4:489-494.

Nonambulatory, severely retarded children with marked spasticity and ranging in age from 3 to 17, institutionalized at Whitten Village, Clinton, S.C., formerly were fed by Levin tubes passed into the stomach 4 to 6 times a day. The formula consisted of a thick mixture of eggs, milk, juices, purées, and vitamins. Difficulties of gavage feedings by nonprofessional personnel and poor weight gain led to a change in the dietary regime. A whole food preparation in powdered form to be mixed with a small amount of liquid was used; it was possible to administer this formula through very small indwelling polyvinyl tubes, passed through the nose and left in place 2 to 3 weeks. Methods for preparing the formula and estimating each child's dietary needs are discussed. The new diet increased the weights of all of the 27 children thus fed over a 6-month period. Another advantage was the elimination of dangers associated with multiple gavage feedings by nurses aides, untrained in this aspect of care.

## OLD AGE—PROGRAMS

*See* 165; 226; 232.

## ORTHOPEDICS

223. **Katz, Jacob F.** *(30 E. 60th St., New York 22, N.Y.)*

Orthopedic problems in children. *Surg. Clinics N. Am.* Aug., 1960. 40:4:1051-1070.

Some of the more common problems in congenital and neonatal deformities, orthopedic problems appearing later in childhood, and those affecting both children and adults are discussed in some detail as to etiology, clinical findings, and treatment. Gross categorization was attempted, using the incidence of pathologic states in certain age groups as a base. Therapy is briefly indicated. Dr. Katz notes especially that several orthopedic conditions, which he names but does not discuss in this article, are not to be construed as of lesser importance or significance.

## PARTIALLY SIGHTED

224. **Weiss, Sidney** *(Pennsylvania Working Home for the Blind, 36th and Lancaster Ave., Philadelphia 4, Pa.)*

Low vision rehabilitation center serves a wide area, by Sidney Weiss and Edythe K. Moore. *Sight-Saving Rev.* Winter, 1960. 30:4:209-211.

The Low Vision Rehabilitation Center, established 2 years ago at the Pennsylvania Working Home for the Blind, attributes its successful record to the excellence of its equipment, to an optician capable of fitting vision aids accurately, and to the services of a dedicated social worker. Results obtained with visual aids in 203 persons are tabulated; an analysis of types of aids given 103 persons is also included. Equipment used, sources of patient referrals, and financial arrangements for services are discussed. Five brief case histories illustrate the value of this unique service. The Center is operated under a Selected Demonstration Project Grant (No. 276) of the U.S. Office of Vocational Rehabilitation.

## PHYSICAL THERAPY

*See* 197; 228; 237.

## POLIOMYELITIS—NURSING CARE

*See* 233.

## PSYCHOLOGICAL TESTS

225. **Ringness, Thomas A.** *(Dept. of Education, Univ. of Wisconsin, Madison, Wis.)*

Self concept of children of low, average, and high intelligence. *Am. J. Mental Deficiency.* Jan., 1961. 65:4: 453-461.

A report of part of a larger research study dealing with the emotional reactions to learning of mentally retarded children (see *Rehab. Lit.*, Mar., 1959, #242; Aug., 1959, #663; and Sept., 1960, #664). Eight scales dealing with self-estimates of achievement in certain school areas (arithmetic, language, reading, peer acceptance, adult acceptance, peer leadership, and success in sports, playground, or game activities) were used. Analysis of the findings showed mentally retarded children have less realistic self-concepts than bright or average children and tend to overestimate success. Self-estimates varied not only with the child, but also with intelligence, sex, and situation. The rating sheet used in the study is appended.

## PSYCHOLOGY

226. **Turner, Helen** *(80-45 Winchester Blvd., Queens Village 27, N.Y.)*

The patient as a person in the treatment relationship.

*J. Health and Human Behavior.* Winter, 1960. 1:4: 278-284.

A social worker with the New York State Department of Mental Hygiene sounds a hopeful note in considering rehabilitation potentials of aging and aged persons. Although goals must be limited in comparison with those for younger patients and the costs of rehabilitation are higher, disability can be decreased even where it is enormous. Good patient-therapist relationships must be established; the therapist should be familiar with the methods and technics of maintaining them. Understanding the individual as he feels and reacts in the role of patient is essential. The psychodynamics of therapy and three overlapping but progressive stages in the aged patient's relationship with the therapist are discussed. Psychological management of the patient at each stage is suggested. This paper was presented at an Institute on Rehabilitation of the Aging, sponsored by the Department of Economics and Sociology, North Texas State College, and held in Dallas in June, 1960.

*See also* 160; 239.

## RECREATION

*See* 239.

## REHABILITATION

**227. Mase, Darrel J.** *(Coll. of Health Related Services, Univ. of Florida, Gainesville, Fla.)*

The increasing importance of total evaluation in rehabilitation. *J. Rehab.* Jan.-Feb., 1961. 27:1:25.

Total evaluations will become more effective and functional when all members of the professional rehabilitation team communicate, co-operate, and collaborate. Primary values and objectives of rehabilitation must be recognized, the particular roles and approaches of other professional disciplines must be understood, and rigid lines between diagnostic and evaluation procedures and the treatment procedures be eliminated. The location of rehabilitation centers should be considered carefully; more efficiency might result from centers closely related to the hospital setting. Professional time could be used to greater advantage if aids were trained to perform routine work under supervision.

**228. La rééducation des traumatisés:** Introduction à la physiopathologie de la rééducation du mouvement, by O. Coquelet; Organisation de la rééducation des traumatisés; expérience pratique d'un Centre de traumatologie, by G. Calberg and M. Stehman. *Acta Orthopaedica Belgica.* 1960. 26:2:96-160.

Dr. Coquelet discusses principles of physical medicine and rehabilitation as practiced in the clinic he directs (Centre de Traumatologie, Brussels). He explains why recovery of tonus requires different exercises than those used in restoring clonic contraction. Drs. Calberg and Stehman describe in detail the organization of the "functional re-education" department of the center, which deals with an average of 150 patients a day. Using both active and passive treatment, group and individual therapy, the center is able to rehabilitate patients more quickly and in better condition. The importance of active methods requiring the collaboration of the patients is emphasized. Illustrated.

Reprints of the brochure may be obtained from Dr. A. Walch, 4, place de Bronckart, Liege, Belgium, at 30 FB each.

**229. Scott, Thomas B.** *(Industrial Relations Center, Univ. of Minnesota, Minneapolis 14, Minn.)*

An index of ease or difficulty of rehabilitation, by Thomas B. Scott and Carroll I. Stein. *Personnel and Guidance J.* Jan., 1961. 39:5:352-354.

A condensation of a portion of the material originally presented in *Minnesota Studies in Vocational Rehabilitation: IV. A Study of 1,637 Counselees (Bul. 24, Nov., 1958),* published by the Industrial Relations Center of the University of Minnesota (see *Rehab. Lit.,* Mar., 1959, #268). Criteria used in developing an index to measure ease or difficulty of rehabilitation are discussed; some weaknesses of the method are considered.

*See also* 162; 189.

## REHABILITATION—GERMANY

*See* 161.

## REHABILITATION—MOROCCO

**230. Dyer, Lois**

Mission to Morocco. *Physiotherapy.* Dec., 1960. 46: 12:350-357. (Congress Lecture)

A British physical therapist, sent to Morocco to aid in the rehabilitation of victims of the recent widespread occurrence of paralysis in that country (see *Rehab. Lit.,* Feb., 1961, #151), tells of the organization of treatment centers, allocation of staff and patients, social problems involved in the treatment program, technics used, and types of disabilities found. Physical therapy methods tended to vary from center to center. The climatic conditions, lack of equipment, and social customs seemed to present great difficulties but results were good under the circumstances.

## REHABILITATION CENTERS—SOUTH AFRICA

**231. Murrell, Marjorie** *(Industrial Rehabilitation Centre, Hippo Rd., Johannesburg, S. Africa)*

The force of rehabilitation to help people in distress. *Rehab. in S. Africa.* Sept., 1960. 4:3:144-154, 190.

In same issue: The role of the accident hospital in rehabilitation, Gerald Machanik. p. 134-137.

The welfare officer of an industrial rehabilitation center in South Africa discusses functions of the social worker as a member of the rehabilitation team. She specifically describes her duties at the Centre, types of disabilities encountered, and technics used in rehabilitation. Case histories of persons treated at the center are used to illustrate rehabilitation problems and their management; 38% of the cases at the Centre resulted from industrial accidents.

Dr. Machanik *(Office of Workmen's Compensation Commissioner, Johannesburg),* while traveling on a World Health Organization Fellowship grant, had opportunity to observe how older European countries and the U. S. managed the rehabilitation of persons injured accidentally. He also describes briefly rehabilitation under workmen's compensation in South Africa.

## REHABILITATION CENTERS—TEXAS

**232. Blashy, Manfred R. M.** *(VA Center, Temple, Tex.)*

Vocational aspects in geriatric rehabilitation. *Texas State J. Med.* Dec., 1960. 56:12:922-924.

Through establishment of sheltered workshops in homes or institutions for geriatric patients, the number who can be returned to productive work in the community can be significantly increased, Dr. Blashy believes. Of the 20 to 25 senior citizens returned each year from a VA Center, a majority were able to work at full- or part-time jobs; their rehabilitation represents a $11,000 yearly saving to the institution. In the workshop residents are tested to determine vocational skills, work tolerance, and physical endurance; they acquire new skills or brush up on old ones and work constructively at their own pace. The costs of adequate rehabilitation facilities are justified by the results achieved, even in the geriatric group.

## RESPIRATION

**233. Powell, B. W.**

Treatment of respiratory paralysis in small children, by B. W. Powell and Mary N. Smith. *Lancet.* Dec. 3, 1960. 7162:1241-1243.

Experience in nursing 11 children, ranging in age from 6 months to 4 years and all having respiratory paralysis caused by acute poliomyelitis, is reviewed. Useful points to remember in establishing the diagnosis of respiratory weakness in young children are cited, as well as considerations in the decision to place the child in a respirator. Nursing care of young respirator patients, use of physiotherapy, and follow-up care of patients are also discussed. Teamwork in poliomyelitis nursing is considered essential in difficult cases requiring respirator care.

## RUBELLA

**234. Great Britain. Ministry of Health**

*Rubella and other virus infections during pregnancy;* a report prepared by Margaret M. Manson, W. P. D. Logan, and Ruth M. Loy. . . . London, H. M. Stationery Off., 1960. 101 p. figs., tabs., forms. *(Reports on Public Health and Medical Subjects, no. 101)*

Based on data gathered in a prospective survey by local health authority officers in England, Scotland, and Wales from 1950 through 1957, the report analyzes conclusions from findings in the more than 7,000 completed cases and controls under review. Two conclusions of importance were demonstrated—that risk of rubella in early pregnancy leading to birth of a malformed infant is much less than earlier studies indicated, and that children born of mothers with a history of rubella during pregnancy should be kept under observation to detect the possible occurrence of deafness. Other virus infections studied did not have the same harmful effects on the fetus as did rubella occurring during the first trimester of pregnancy. Malformations of the heart, cataract, and deafness were the most common defects noted in children studied for this report. Earlier retrospective and prospective studies made in various countries are reviewed briefly in the introduction.

Available in the U.S. from British Information Services, 45 Rockefeller Plaza, New York 20, N.Y., at $1.35 a copy.

**235. Skinner, Clifford W., Jr.** *(4200 W. Ninth Ave., Denver, Colo.)*

The rubella problem. *Am. J. Diseases of Children.* Jan., 1961. 101:1:78-86.

Another of the seminar reports from the University of Colorado's Department of Pediatrics (for first, see *Rehab. Lit.,* Feb., 1961, #100). In this review of recent developments in regard to rubella, the author discusses components of the syndrome, incidence of congenital anomalies in infants of mothers who developed rubella during pregnancy, clinical findings in regard to the disease, and preventive measures to reduce possibility of congenital anomalies. It is emphasized that, in spite of immunity to rubella in the mother, the fetus may still be attacked by the rubella virus in the first trimester. 28 references.

## SHELTERED WORKSHOPS

**236. Garrett, James F.**

Whither workshops? *Rehab. Record.* Nov.- Dec., 1960. 1:6:9-12.

An edited and shortened paper based on Dr. Garrett's keynote address presented at the Training Institute for Rehabilitation Workshop Directors, sponsored by Los Angeles College and the California Conference of Workshops for the Handicapped, held at Pacific Palisades, Calif., in February, 1960. (Full report of the Conference was annotated in *Rehab. Lit.,* Oct., 1960, #769.)

*See also* 232.

## SHOULDER

**237. Murray, William** *(Dept. of Physical Medicine and Rehabilitation, Long Island Jewish Hosp., New Hyde Park, N.Y.)*

The chronic frozen shoulder; conservative measures of mobilization. *Phys. Therapy Rev.* Dec., 1960. 40:12: 866-874.

Successful restoration of motion in the "frozen shoulder," a term commonly applied to chronic immobility of the arm-trunk mechanism, particularly the glenohumeral joint, calls for judicious use of physical therapy. A brief review of the etiology and pathology of the condition is given, followed by a description (with illustrations) of mobilization methods—electrical stimulation and manual and mechanical technics. The author's observations, based on experience with such patients, concur with those of Simmonds (see bibliography accompanying article)—that there is universal loss of glenohumeral mobility in all directions. Others view this primarily as losses in abduction and external rotation.

## SOCIAL SECURITY ACT

**238. U. S. Bureau of Old-Age and Survivors Insurance**

*Report and recommendations of the Medical Advisory Committee on the administration of the OASI disability provisions.* Washington, D.C., Govt. Print. Off., 1960. 16 p.

The first Committee report, transmitted in July, 1955, has been expanded in the second to include a summarization of activities of the Committee from its inception to date. Composed of representatives from a wide variety of medical and related professional specialties, the Committee

is responsible for advising the Social Security Administration on medical aspects of the disability "freeze" provisions of the social security program. Legislative background of the provisions is discussed briefly. Recommendations are made on methods of operation to establish proof of disability, use of medical report forms and disability evaluation guides, administrative policies affecting incentives to work, responsibilities of state agency review teams, and interpretation of the program to professional and other groups.

Available from U.S. Superintendent of Documents, Washington 25, D.C., at 15¢ a copy.

## SOCIAL SERVICE—GROUP WORK

239. **Cole, Minerva G.** *(29 Bolton Lane, Levittown, N.J.)*

Serving handicapped children in group programs, by Minerva G. Cole and Lawrence Podell. *Soc. Work.* Jan., 1961. 6:1:97-104.

As part of the 3-year Demonstration Project on Group Work with Handicapped Children, sponsored by the Community Council of Greater New York, a questionnaire survey was made to determine attitudes of directors of group work and recreation agencies in New York City toward serving the handicapped. Difficulties in programing for handicapped children were investigated. Inexperienced directors revealed attitudes toward the handicapped similar to attitudes toward minority groups. Their stereotyped ideas caused directors to view handicapped children in a separate category, needing unusual and expensive special care and facilities. It is suggested that social work students be provided contacts with the handicapped.

## SPECIAL EDUCATION—JAPAN

240. **Izutsu, Satoru** *(Highland View Hosp., 3901 Ireland Dr., Cleveland, Ohio)*

Special education of handicapped children in Japan, by Satoru Izutsu and Marvin E. Powell. *Exceptional Children.* Jan., 1961. 27:5:252-259.

Mr. Izutsu, a registered occupational therapist working in the Sheltered Workshop Research Project at Highland View Hospital, Cleveland, made a 6-week study of special education programs for exceptional children in Japan during 1959. Factors seen as influencing education of exceptional children in Japan are: the American military occupation, the decentralization of the family system, the changing social structure, and, finally, the altering belief in traditional Buddhism. Discussed are legislation, teacher qualifications, role of parents, use of special equipment and services, record keeping, financial aid, statistics on special school enrollment, placement of pupils, and services for children in various categories of disability. Needs to be met are considered. The study was conducted under the auspices of the International Society for Rehabilitation of the Disabled and the Japanese National Committee of the International Society.

## SPEECH CORRECTION

241. **Boone, Daniel R.** *(11206 Euclid Ave., Cleveland 6, Ohio)*

Relationship of progress in speech therapy to progress in physical therapy. *Arch. Phys. Med. and Rehab.* Jan., 1961. 42:1:30-32.

At Highland View Hospital, Cleveland, 153 patients with hemiplegia or multiple sclerosis received both speech and physical therapy; the possible relationship between progress achieved in speech and language functions and the degree of physical independence achieved after completing physical therapy was evaluated. In 74% of the patients no significant relationship was evident between rate of progress in the two areas. One implication of the findings is that it is not possible to predict by physical status alone those patients who will do well in speech therapy. Patients too physically or psychologically involved to profit from physical therapy are usually not good candidates for speech therapy. Among those who do well in physical therapy there is an approximate 50% expectancy of benefit from speech therapy.

*See also* 158.

## SPEECH CORRECTION—STATISTICS

242. **Newman, Parley W.** *(1001 Connecticut Ave., N.W., Washington 6, D.C.)*

Speech impaired? *Asha.* Jan., 1961. 3:1:9-10.

The very wide discrepancy between estimates of prevalence of speech impairment, as reported by the American Speech and Hearing Association and the U.S. Public Health Service's National Health Survey, calls for reexamination of what actually constitutes a "handicapping" condition in speech. Mild deviations of speech that do not impair emotional, social, or economic relationships should not require treatment. Such a viewpoint could eliminate unnecessary service and influence current beliefs and practices that would, in turn, affect training programs, research, and administration of services.

## VOCATIONAL GUIDANCE

*See* 175; 176.

---

*(Continued from page 81)*

ships, with an average individual cost of about $5,600 and total cost of about $994,800. Of these, 84 1/3 were used by 19 institutions of higher learning and 93 1/6 by state educational agencies. Experience indicates continued demand for grants with keen competition.

The federal government has contributed significantly to progress in attaining knowledge and insight into crucial problems, particularly through the co-operative research program of the Office of Education. Since the program's start in 1956, over 100 research projects in special education have been contracted for by colleges, universities, and state education agencies. Nearly two-thirds of the studies focus on education of mentally retarded children, and the remainder on important educational problems of children who are blind, deaf, hard of hearing, speech impaired, socially maladjusted, or gifted. Findings from many research projects are already available for use in improving existing programs or as a basis for planning new programs.

## Clergymen's Guide to Welfare Agencies Issued in New York

THE NEW YORK State Department of Health *(84 Holland Ave., Albany 8, N.Y.)* has issued a 55-page booklet *A Clergyman's Guide to Health and Welfare Services in Official Agencies in New York State* (1960). The *Guide* briefly discusses problems that clergymen encounter frequently and for the control of which formal programs exist in official public health agencies. A directory of agencies is given in the latter half of the *Guide.*

## New Head of Psycho-Educational Research at Gallaudet College

PRES. LEONARD M. ELSTAD has announced the appointment of Jerome D. Schein, Ph.D., as director of the Office of Psycho-Educational Research of Gallaudet College. The position was formerly held by Stephen P. Quigley, Ph.D., who resigned to become executive secretary of the Sensory Disabilities Research Study Section, U.S. Office of Vocational Rehabilitation. Dr. Schein has been affiliated with Gallaudet College since September, 1960, when he was appointed professor of psychology and clinical psychologist on the staff of the College's new Counseling Center for the Deaf. He holds the degree of Ph.D. in Clinical Psychology (1958) from the University of Minnesota. Dr. Schein's doctoral dissertation was entitled "An Experimental Investigation of Some Psychological Functions in Detection of Brain Damage."

## *Dr. Kistiakowsky Comments on* Science and Medicine

"THE STARTLING SUCCESSES of medical research in the past two decades have dramatically altered the nature of the problems facing us today. Most of the 'single' cause diseases have been conquered. Except for those of virus etiology, communicable diseases are rare in this country. Several nutritional or metabolic disorders such as rickets and diabetes have been eliminated or can be controlled. Today, medical research is faced with multiple cause diseases involving such complex factors as environment, pollution, diet and aging. Cancer, arthritis and many forms of mental disorders appear unresolvably complex. Persistence and courage in defeat will be required to solve the problems of degenerative diseases."—*George B. Kistiakowsky, Ph.D., at the dedication, Nov. 17, 1960, of the Alfred H. Caspary Research Building, The Hospital for Special Surgery, 535 E. 70th St., New York 21, N.Y.*

## Sheltered Workshops in England To Expand Program

REMPLOY, which now employs some 6,300 handicapped in 90 factories in Britain, will soon be able to raise the number to 7,300 or 7,500. The British government will make a £1.75 million capital grant to Remploy for a 5-year period beginning this April 1, with an additional £50,000 annually to help cover costs. Remploy's sales of a wide variety of products in 1959-1960 totalled £5,143,000. The company had passed an important commercial milestone as sales income then exceeded the cost of raw materials and wages paid to disabled employees.

Two interesting medical aspects of Remploy's work are the company's part in the rehabilitation of people suffering from schizophrenia and the opening to other workers of factories previously reserved solely for tuberculosis patients.

## Centers Study Birth Defects

THE FIRST OF ITS KIND in the United States, the Birth Defects Center, The Children's Hospital *(561 S. 17th St., Columbus 5, Ohio)*, began its second year on Jan. 5. In 1960 more than 500 visits were made by 126 patients. Hydrocephalus and myelomeningocele are the main focus of the Center.

The National Foundation, which supports the Center, has established a second center in Nashville, Tenn. A third will be in Oklahoma City, Okla.

## Hartford Rehabilitation Center To Demonstrate Aid to Emotionally Ill

THIS SPRING a $60,000 pilot study will begin at the Hartford Rehabilitation Center to demonstrate the effectiveness of a center in serving the emotionally disabled. It will be operated with the Greater Hartford Mental Health Association co-operating over 3 years, aiding some 75 patients to move from the mental hospital to a job.

Services will include psychiatric evaluation and supervision, social service, psychological testing and counseling, occupational therapy, vocational counseling, and pre-employment training. Miss June Sokolov, Center director, stated 15 percent of those in mental institutions would be enabled to return to normal living sooner with this type of service.

A psychologist from the University of Hartford will be project co-ordinator. The Center's staff will have 6 or 7 part- and full-time personnel added to its staff.

Some 20 rehabilitation centers of 86 surveyed are now serving ex-mental patients.

## ARF Bulletin Reviews 10 Years Of Steroid Joint Injections

TEN YEARS OF injecting cortisone-related steroids directly into arthritic joints show that, administered in this way, these hormone drugs relieve pain and reduce swelling in the joint itself, in 90 percent of cases. These results are summed up in an article in the January, 1961, issue of the Arthritis and Rheumatism Foundation's monthly publication, the *Bulletin on Rheumatic Diseases.*

Reporting on over 100,000 injections given some 4,000 patients at the University of Pennsylvania arthritis clinic in the last decade, Drs. Joseph L. Hollander, Ralph A. Jessar, and Ernest M. Brown, Jr., point out that relieving symptoms does not cure arthritis. They add that relief itself varies and is often temporary. However, fresh injections continue to provide relief and can be repeated (in one case up to 142 times) in a chronically inflamed joint without apparent harmful effect.

It is this "repeatability," the authors explain, that makes this type of therapy valuable in long-term treatment of the most serious forms of arthritis, rheumatoid and osteoarthritis. These diseases account for most of the 11 million victims of arthritis in the United States and by far the greatest number of severely crippled sufferers.

While local injections of steroids do not stop the progress of rheumatoid arthritis or the degeneration of osteoarthritis, the temporary easing of pain and swelling enables sufferers to keep active in relative comfort and accelerates rehabilitation.

The article emphasizes that other forms of therapy must accompany steroid joint injections in treating severe types of arthritis. It also stresses the need for the physician to keep patients under continued observation during steroid therapy and to avoid the drugs when infection in the joint is present or suspected.

One adverse side effect noted is instability developing in repeatedly injected weight-bearing joints, such as the hip or knee, occurring in about .7 percent of cases. The authors suggest that regular x-ray examinations and protection of these joints during treatment by steroid injection may help detect and avoid this danger.

Among the steroid compounds used in the study were hydrocortisone acetate, prednisolone acetate, methylprednisolone acetate, triamcinolone acetonide, and dexamethasone acetate. Though the exact way in which these drugs alleviate arthritis symptoms is still undetermined, the Philadelphia physicians were able to report that swelling, tenderness and pain in joints usually decreased within 24 hours of injection, reaching a peak of effectiveness by the third day.

## *Dr. Willard A. Wright Comments on*

### Hospital-Nursing Home Relationships

"THIS WORKSHOP WAS SPONSORED and planned by the American Hospital Association, American Medical Association, American Nursing Home Association, Blue Cross Commission and the U.S. Public Health Service. It was convened in the belief that a joint conference at the national level to explore methods of developing effective hospital-nursing home relationships could stimulate the holding of similar conferences at the state and local levels. We did not expect that we could solve all the problems in this workshop. Rather, we hope that ideas emerging from this interdisciplinary discussion will be considered in depth at community workshops and specific solutions will thus be found for the particular problems of the individual community. . . . Six major problems that emerged from the discussions were:

I. Need for continuity of care and free flow of patients into the appropriate facility at the right time.

II. Need for community planning for total health facilities.

III. Need for mutual understanding and communication among the various providers of health services.

IV. Inadequate financing.

V. Need for more well-qualified personnel at all levels.

VI. Need for rehabilitation. . . .

*Need for Rehabilitation*

"The philosophy and concepts of mental and physical rehabilitation on a continuous basis from admission to discharge within the hospital and the nursing home, without interruption between them, should be applied to the long-term patient. Mental and physical rehabilitation are considered to be interlocking.

"It is essential that all personnel in the hospital and nursing home have the philosophy, concept and ability to motivate and assist the patients *to do for themselves* to achieve a maximum of self-reliance within their individual limitations. Educational programs for personnel should be developed to bring about re-education towards these rehabilitative concepts.

"In order to achieve continuity of rehabilitative services, several proposals were made. Among these were:

A. Develop special centers in key locations in the state to provide guidance, consultation, education and special services for both patients and personnel.

B. Request the state to establish a mobile rehabilitation unit to go from nursing home to nursing home to teach the nursing home personnel procedures in rehabilitation.

C. Include in the postgraduate education of physicians emphasis on recognizing the potential of rehabilitation of the patient.

D. Nursing personnel should have knowledge of basic physical therapy techniques. It is felt that simple rehabilitation skills are really a part of good nursing care."

—*From* Proceedings of Workshop on Hospital-Nursing Home Relationships . . . Chicago, February 23-25, 1960. *60 p. 1960. Available from Council on Medical Service, American Medical Association, 535 N. Dearborn St., Chicago 10, Ill.*

### Benefits of Rocking Described

A PHYSICIAN PRACTICING in Ontario, Canada, in a special article in the Dec. 31, 1960, issue of *Lancet* described the excellent physical and mental state of older people who habitually use rocking chairs. Dr. R. C. Swan suggests that this form of dignified exercise, which can be done while a part of the family or social group, has many beneficial effects: on forearm and calf muscles and venous return, increasing cardiac output, circulation, and absorption of dependent edema; on respiration, discouraging formation of hypostatic pulmonary congestion; on movement, stimulating muscle tone and encouraging supple joints; on sleep, through its repetitive and sedative effects. His observations are the result of weekly visits to homes of some 40 families. He points out the rocking chair is cheap, easily obtainable, has no side effects, is nontoxic, and needs no prescription.

In the Jan. 14, 1961, issue of the same journal, Joseph Yahuda of London replies to Dr. Swan's article, saying that he believed the good resulting from the rocking was not a result of local muscular exercise accompanying the very limited exertion, but of the universal cellular and visceral exercise, which can be obtained with no exertion. During World War II, he invented a mechanical swing and now sleeps most nights in an electrically propelled model. He believes many disabled persons would benefit from this form of internal exercise, which entails no exertion, displacement, external movement, or manipulation, and that scientific research in this field would yield rich rewards.

### ICD Appoints New Director

JAMES N. BURROWS has been appointed director of the Institute for the Crippled and Disabled, succeeding the late Willis C. Gorthy, who died on Dec. 4. Mr. Burrows was formerly the Institute's director of patient programs. He has been engaged for the past 20 years in the management and administration of government and private rehabilitation and medical programs. Before joining the Institute in 1957, he was the administrator of Rehabilitation Center, Inc., Louisville, Ky.

## *Morton A. Seidenfeld Comments on*

### Physically Handicapped Children And Educational Losses

"AS I STUDY the statistics of polio children, of youngsters with rheumatoid arthritis and many other diseases, I am appalled by the frequency with which we find evidence of school retardation in children who are quite capable of normal or even above normal school work. Those who wish to rationalize are quick to say their medical treatment prevented their being schooled. Yet, thirty years of intimate relation to the treatment scene has convinced me that more often than not it is a disregard for the need to maintain the child's education, a feeling that it is less important than treatment of the disease at hand. I admit to a bias and anyone may challenge my point of view. But I cannot see any reason for fighting so desperately to get a child physically well while at the same time failing to recognize that with very little more effort you can maintain that child's motivation and save him needless embarrassment and humiliation by simply providing some educational facilities as an integral part of the treatment environment."

—*From "Advances in Medicine and Health Affecting Special Education," by Morton A. Seidenfeld, Ph.D., p. 47, in* Proceedings of the Second Arkansas Conference for the Handicapped: Educating the Handicapped. . . . April 16 and 17, 1959, Little Rock, Sponsored by the Nemours Foundation and the Arkansas Council for the Handicapped. *66 p. The Nemours Foundation (1959?).*

### APTA To Convene in July

THE 38TH CONFERENCE of the American Physical Therapy Association will be held at the Palmer House, Chicago, Ill., on July 2 to 7, 1961. "Aftercare Programs" will be the theme of the scientific program, which will deal with the pediatric patient, the ambulatory adult, and the geriatric patient.

### Institute Concludes Series on *Self-Help Devices in Rehabilitation*

WITH ITS 12TH REPORT, the Institute of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center *(400 E. 34th St., New York 16, N.Y.)*, is closing its project on *Self-Help Devices for Rehabilitation.* In 1950, under a grant from the National Foundation for Infantile Paralysis, the Institute began its study for the purpose of disseminating knowledge on self-help devices to hospitals, physicians, and patients. Now the term is well understood and all items most widely used are available commercially. The final report of various devices not previously reported is illustrated with photos and diagrams and gives sources and costs of equipment.

Postage Will be Paid by Addressee

No Postage Stamp Necessary If Mailed in the United States

**BUSINESS REPLY MAIL**

First Class Permit No. 37727, Chicago, Ill.

**REHABILITATION LITERATURE**
**The National Society for**
**Crippled Children and Adults**
**2023 W. Ogden Avenue**
**Chicago 12, Illinois**

# *Author Index*